Schollmeyer Family Chiropractic

2415 E 23rd Ave. South, Suite 200, Fremont, NE 68025 ~ 402-721-5500

About this Patient:

First Name _____ Last Name _____ Email _____
Street Address _____ City _____ Cell Phone _____
State/Province _____ Zip Code _____ Home Phone _____
Employer _____ Type of Work _____ Work Phone _____
Work Address _____ Work City _____ Work State _____
Social Security # _____ Birthday _____ Age _____
Marital Status: *Married* *Single* *Divorced* *Widowed* Gender: *Male* *Female* *Other*

About the Spouse or Parent/Guardian:

First Name _____ Last Name _____ Employer _____
Work Address _____ Work City _____ Work State _____
Type of Work _____ Work Phone _____

Reason for this Visit:

Is appointment related to: *Work Incident* *Sports Injury* *Auto Accident* *Chronic Discomfort* *Home Injury* *Other*
Please explain: _____

Have you been in an Auto Accident in the past 6 months? *Yes* *No*
If job related, have you made a report of your accident to your employer? *Yes* *No*
When did this condition begin? _____ Has this condition: *Gotten Worse* *Stayed Constant* *Comes & Goes*
Does this condition interfere with: *Work* *Sleep* *Daily Routine* *Other Activities*
Please explain: _____

Has this condition occurred before? *Yes* *No* Please explain: _____

Have you seen other doctors for this condition? *Yes* *No*
Doctor's Name(s) _____
Type of Treatment: _____
Results: _____

Initial Consultation:

Primary Complaint (s): _____

Overall frequency of complaint: *Constant - 100% of the time* *Frequent - 75%* *Intermittent - 50%* *Occasional - 25%*
Overall intensity of complaint:
- ☐ Severe (Intolerable and cannot perform any activities)
- ☐ Moderate (Tolerable with marked impairment of activity)
- ☐ Slight (Tolerable with some impairment to activity)
- ☐ Minimal (An annoyance but has no effect on activity)

Is this problem affecting any other area of your body? *Yes* *No* If *YES*, please explain: _____

Does it interfere with your normal daily activities (Family, Work, Recreation, Sports)? *Yes* *No* If *YES*, please explain:

Do your symptoms increase while performing your normal work duties? *Yes* *No* If *YES*, please circle the amount below that you feel your symptoms increase at work: *0%* *10%* *20%* *30%* *40%* *50%* *60%* *70%* *80%* *90%* *100%*

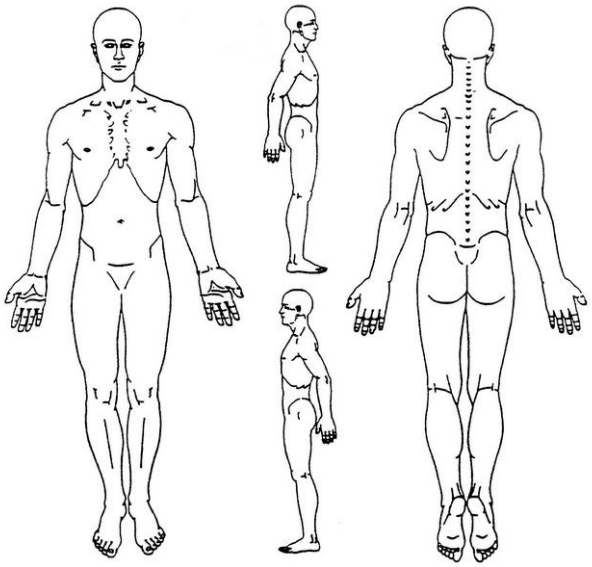
What aggravates the problem? _____

What relieves the problem? _____

If this problem went without being taken care of, how do you think it would affect you? _____

_____

Place an X on the image below, where you feel Pain, numbness or tingling:



Medications You Are Currently Taking:

- ☐ Pain Killers (including Aspirins)
- ☐ Blood Pressure Medicine
- ☐ Cholesterol Medicine
- ☐ Stimulants
- ☐ Muscle Relaxers
- ☐ Blood Thinners
- ☐ Tranquilizers
- ☐ Nerve Pills
- ☐ Insulin
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

☐ I've given the Doctor a list of my medications.

Health Conditions:

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or Frequent Headaches	☐ Dizziness	☐ Sleeping Problems	☐ Fatigue
☐ Pins and Needles in Arms/Legs	☐ Fainting	☐ Loss of Smell/Taste	☐ Tension
☐ Numbness in Arms/Legs/Hands	☐ Loss of Balance	☐ Problem Urinating	☐ Fever
☐ Buzzing/Ringing in Ears	☐ Lights Bother Eyes	☐ Constipation	☐ Neck Stiff
☐ Cold Sweats/Hot Flashes	☐ Irritability	☐ Ulcers	☐ Neck Pain
☐ Menstrual Irregularity	☐ Mood Swings	☐ Heartburn	☐ Back Pain
☐ Menstrual Pain	☐ Depression	☐ Upset Stomach	Other _____
☐ Cold Hands/Feet	☐ Nervousness	☐ Diarrhea	Other _____

Experience with Chiropractic:

Who referred you to this office? _____

Have you been adjusted by a chiropractor before? *Yes* *No* Doctor's Name: _____

If *YES*, what was the reason for those visits? _____

Approximate date of last visit? _____

Has any adult in your family seen a Chiropractor? Yes No

Has any child in your family seen a Chiropractor? Yes No

Acknowledgment:

The information submitted above is complete and accurate, to the best of my knowledge.

Patient or Parent/Guardian please sign below:

Signature: _____ Date: _____

Printed Name: _____