**Sjogren Chiropractic Center Inc.**
113 ½ Main St. Unit 1
Oxford, MA 01540
P(508) 499-3919, F(508) 499-3726

Date____/____/_____ Chart#_____

Name _____
(Last) (First) (Middle Initial)

How did you hear about us? □Phonebook □Internet □Family/Friend □Primary Care Physician □Mailing □Sign □Other_____

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Have you ever had chiropractic care before? _____
For what problem? _____
Were the results satisfactory? Yes_____ No_____ N/A_____
Major complaints and symptoms - please be as specific as you can. Ask for help if you need assistance in filling out this section._____
_____
_____
How do you believe your problem (pain) began?_____
_____
_____
When did you first notice this problem/pain? _____
Have you lost any work? _____ Day and date you last worked _____
Have you ever had this condition before or a similar condition? _____
When? _____
What positions or activities aggravate your condition? _____
What positions or activities relieve your condition? _____
Have you ever been treated by a Medical Physician for this ailment?_____
Describe the type of treatment _____
Diagnosis of previous physician _____
Length of time under care_____ Results _____
Family physician's name _____
Have you ever been in any accidents or falls (even as a child)?_____
_____
_____
Are you presently taking any medication, herbs, or over the counter products?
If yes, name them _____
Have you ever broken any bones? (fractures) _____
Any dislocations? _____

What operations have you had? _____Year _____
_____Year _____
Give dates you have had any of the following? (if exact date is unknown, give approximate)

MRI _____ CT Scan _____ Ultrasound _____
Radiation Treatment _____ X-Ray examination _____
Other special treatment _____
At what hospital or office were these tests taken _____
Name of doctor who ordered tests _____
Do you have any health problems not listed above? _____
Do you take vitamins? Yes_____ No _____ If yes, please list them _____

**Continues on back side**

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Do you exercise regularly? Yes _____ No _____ What kind of exercise? _____

Habits: (please check)
Cigarettes _____ Quantity _____ Coffee? _____ Quantity _____
Alcohol? _____ Quantity _____ Tea? _____ Quantity _____
Hobbies _____
Have you been treated for any health condition by a physician in the past year? _____
If yes, what condition? _____
Have you lost or gained weight in the past year? _____

**Please circle the number that relates to the symptoms listed below**

0 = Never 1 = Occasional/Mild 2 = Often/Moderate 3 = Constant/Sever

| | | |
|---|---|---|
| Headaches……..... 0 1 2 3 | Seasonal allergies….. 0 1 2 3 | Low blood pressure..... 0 1 2 3 |
| Bleeding gums……..... 0 1 2 3 | Diarrhea..... 0 1 2 3 | Muscle aches..... 0 1 2 3 |
| Itchy skin..... 0 1 2 3 | Sleep walking……..... 0 1 2 3 | Wake up tired..... 0 1 2 3 |
| Eyes painful..... 0 1 2 3 | Asthma..... 0 1 2 3 | Heart palpitations..... 0 1 2 3 |
| Coated tongue……..... 0 1 2 3 | Stomach ulcers……... 0 1 2 3 | Pain in arms or legs ..... 0 1 2 3 |
| Hot/cold spells……..... 0 1 2 3 | Bed wetting……....0 1 2 3 | Anxious/nervous…….. 0 1 2 3 |
| Blurry vision……..... 0 1 2 3 | Night sweats..... 0 1 2 3 | Difficulty breathing….. 0 1 2 3 |
| Pressure/pain in head….0 1 2 3 | Hemorrhoids……..... 0 1 2 3 | Arthritis..... 0 1 2 3 |
| Ringing in ears..……..... 0 1 2 3 | Frequent urination..... 0 1 2 3 | Irritable..... 0 1 2 3 |
| Dizziness..... 0 1 2 3 | Chest discomfort…..... 0 1 2 3 | Out of breath easily..... 0 1 2 3 |
| Indigestion..... 0 1 2 3 | Jaundice……..... 0 1 2 3 | Sensitive/tender skin... 0 1 2 3 |
| Faintness……..... 0 1 2 3 | Burning on urination.. 0 1 2 3 | Depression ..... 0 1 2 3 |
| Upset stomach……..... 0 1 2 3 | Chest pains..... 0 1 2 3 | Swollen ankles…..... 0 1 2 3 |
| Numbness/tingling…... 0 1 2 3 | Liver/Gall bladder..... 0 1 2 3 | Stressed..... 0 1 2 3 |
| Twitching..... 0 1 2 3 | Lose bladder control .. 0 1 2 3 | Cold hands/feet…..... 0 1 2 3 |
| Frequent colds..... 0 1 2 3 | High blood pressure.... 0 1 2 3 | Bruise easily……..... 0 1 2 3 |
| Constipation..... 0 1 2 3 | Painful joints..... 0 1 2 3 | Trouble sleeping…….. 0 1 2 3 |
| Epilepsy/seizures ..... 0 1 2 3 | | Leg cramps..... 0 1 2 3 |
| | | Rashes/boils..... 0 1 2 3 |

**System Review:** Do you have any problems, symptoms, dysfunction or difficulties involving the following body systems that you did not check off above? If so, please explain.

- ☐ Coronary/Vascular System_____
- ☐ Digestive System_____
- ☐ Endocrine System_____
- ☐ Immune System_____
- ☐ Nervous System_____
- ☐ Reproductive System_____
- ☐ Respiratory System_____
- ☐ Urinary System_____

_____ _____
Patient/Guardian signature Date