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Starkey Chiropractic, Neck & Low Back Pain Center
312 Center Street, Ashland OH 44805
Phone: 419-289-0330

Date:_____

Last name: _____First name: _____M: ___ Sex: _____Birth Date: _____ Age: _____

SSN: _____ Email:_____ Married: ____ Single:____ Sep./Div.:___ Wid.:___

Home phone: _____ Cell phone: _____ Work phone:_____

Address: _____ City: _____ County: _____State: _____ Zip: _____

Patient's Employer: _____Occupation: _____Referred by:_____

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Name on Insurance account: _____**Relationship to patient:** _____

SSN: _____ **Birth date:** _____ **Employer:** _____

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Chief concern: _____

1. When did your symptoms begin (onset date)? _____
2. How did your symptoms begin? _____
3. Have you experienced these before? _____
4. Do your symptoms radiate? _____
5. Has your condition? Improved ____ Gotten Worse _____ Stayed the same since it began _____
6. Circle the things that make your problems worse:

   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
7. Is there anything you can do to relieve the problem? No ___ Yes ____ Describe _____

   If No, what have you tried that has not helped? _____
8. Have you been treated for this before? No ____Yes _____ How long ago? _____
9. What treatment did you receive? _____
10. Results of previous treatment? Good ____Poor _____ Comments _____
11. Is this condition interfering with: Work ____Sleep _____Daily Routine ____Recreation _____
12. List any other major injuries you have had, other than those mentioned above: _____
13. Any other Musculoskeletal problems? No ____Yes _____ Neurological problems? No ____ Yes _____
14. Present Medications / Supplements _____
15. Past medical history (hospitalizations, surgeries) _____
16. Cigarette smoker?_____ Alcohol use? _____

Please turn over and complete the other side.