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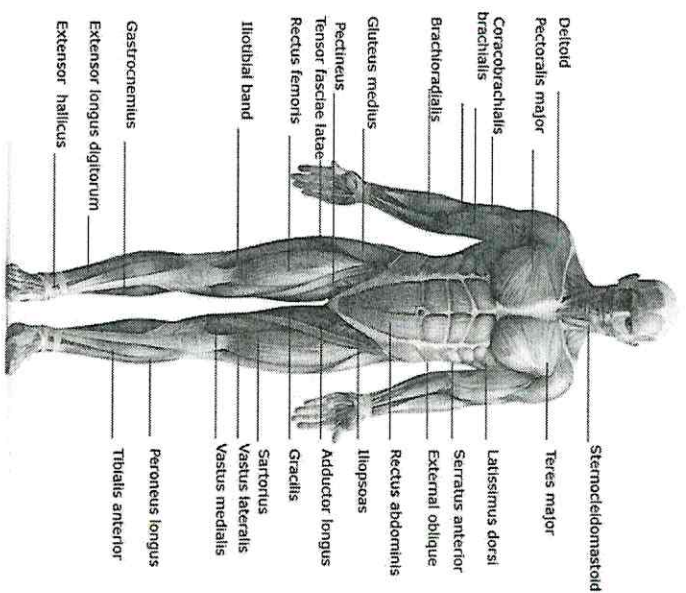
MEDICATIONS/PAST SURGERIES/TREATMENT/DATES

NAME:			
ADDRESS:			
CITY STATE ZIP:			
DATE OF BIRTH:	AGE:		
SEX: MALE FEMALE (circle one)			
MARITAL STATUS: Single Married Divorced Widowed			
SSN #:			
HOME PHONE:			
CELL PHONE:			
WORK PHONE:			
EMAIL ADDRESS:			
EMERGENCY CONTACT NAME:			
EMERGENCY CONTACT PHONE:			
WERE YOU REFERRED? BY WHO?		PRIMARY CARE DOCTOR:	
FOR INSURANCE PURPOSES ONLY:			
ARE YOU THE SUBSCRIBER OR DEPENDENT? YES NO		DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE)	
SUBSCRIBER'S NAME:	BLOOD CLOT	HEART DISEASE	METAL SPINE IMPLANT
SUBSCRIBER'S DOB:	CANCER	SPINAL SURGERY	PACE MAKER
INJURY: AUTO WORK OTHER	BIRTH CONTROL	STROKE	PREGNANT
DATE OF ACCIDENT:	PROSTHETIC DEVICE		

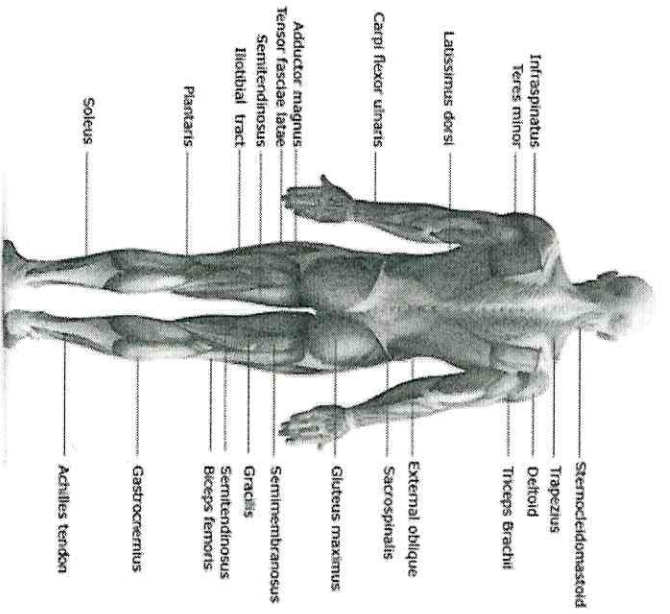
SYSTEMS REVIEW: (circle Y or N if experiencing problems)		LOST OF BOWEL/BLADDER?		Y	N	UNEXPECTED WEIGHT LOSS?		Y	N
CHEST PAIN	Y N	MEMORY	Y N	SINUSES	Y N	BREAST PAIN	Y N		
BREATHING	Y N	DIZZINESS	Y N	HEARTBURN	Y N	JOINT PAIN	Y N		
BLOOD PRESSURE	Y N	CONFUSION	Y N	THIRST	Y N	STIFFNESS	Y N		
VEINS	Y N	FAINTING	Y N	URINATION	Y N	JAW	Y N		
SWELLING	Y N	VISION	Y N	MENSTRUAL	Y N	DRUGS	Y N		
DEPRESSION	Y N	HEARING	Y N	CRAMPS	Y N	ALCOHOL	Y N		

PLEASE CIRCLE AREAS OF PAIN ON THE PICTURES BELOW AND LABEL HOW IT FEELS (SHARP, ACHE, BURN, NUMB, OR OTHER)

Major Anterior Muscles



Major Posterior Muscles



LIST COMPLAINTS/ DESCRIPTIONS AND ANSWER THE QUESTIONS IN THE COLUMNS BELOW

	COMPLAINT #1	COMPLAINT #2	COMPLAINT #3
WHEN DID THE COMPLAINT BEGIN? HOW MANY TIMES OVER THE YEARS HAVE YOU HAD THIS?			
HOW OFTEN DO YOU HAVE PAIN?			
HOW LONG DO EPISODES LAST?			
INTENSITY: MILD, MODERATE, SEVERE			
WHEN IS IT THE WORST?			
DOES IT WAKE YOU FROM A DEEP SLEEP?			
WHAT RELIEVES THE PAIN?			

NOTES/COMMENTS: