

**SYLVIA CHIROPRACTIC CENTER**  
**2601 N HERRITAGE STREET**  
**KINSTON, NC 28501**  
**(252) 523-1900**

Proper First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Street Address & Number: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Social Security Number: \_\_\_\_\_ Marital Status: (circle one) Single Married Divorced Widowed # of Children: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Status:  Full Time  Part Time  
 Student:  Full Time  Part Time

Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

◆ Are today's problems related to:  Auto Injury  Workman's Compensation  Neither

◆ Describe your condition(s) beginning with the most severe. Please rate each condition on a scale of 1 to 10 (10 being worst)

1. \_\_\_\_\_ ( \_\_\_\_ / 10) 2. \_\_\_\_\_ ( \_\_\_\_ / 10)

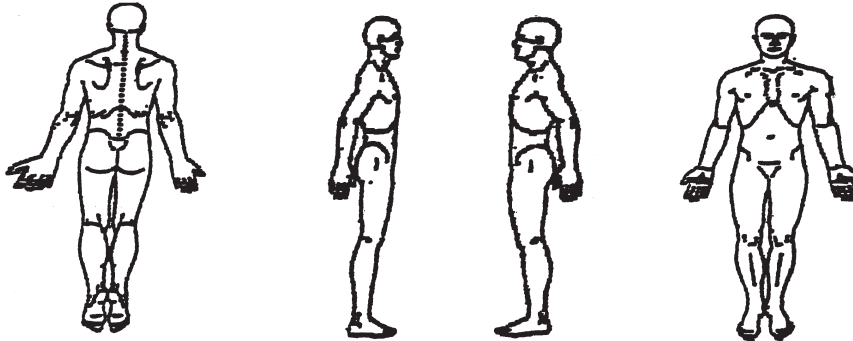
3. \_\_\_\_\_ ( \_\_\_\_ / 10) 4. \_\_\_\_\_ ( \_\_\_\_ / 10)

5. \_\_\_\_\_ ( \_\_\_\_ / 10) 6. \_\_\_\_\_ ( \_\_\_\_ / 10)

◆ How often do you experience pain?  Constantly (75-100%)  Frequently (50-75%)  Occasionally (25-50%)  Intermittently (1-25%)

◆ How would you describe the type of pain?  Ache  Dull  Burn  Sharp  Shooting  Numb  Other

◆ Please indicate on the diagram below where you have symptoms:



◆ How are your symptoms changing with time?  Getting Worse  Not Changing  Getting Better

◆ How much has your problem interfered with your work?  Not At All  A Little Bit  Moderately  Quite A Bit  Extremely

◆ How much has the problem interfered with your social activities?  Not At All  A Little Bit  Moderately  Quite A Bit  Extremely

◆ Who else have you seen for your problem?

- Chiropractor  Neurologist  Primary Care Physician  ER Physician  No One  
 Orthopedist  Massage Therapist  Physical Therapist  Other: \_\_\_\_\_

Who? \_\_\_\_\_ Treatment? \_\_\_\_\_ Results: \_\_\_\_\_

◆ Who is your family physician? \_\_\_\_\_

◆ How long have you had this problem? \_\_\_\_\_

◆ How do you think your problem began? \_\_\_\_\_

◆ Do you consider this problem to be severe?  Yes  Yes, At Times  No

◆ What aggravates your problem? \_\_\_\_\_

◆ What makes your problem better? \_\_\_\_\_

◆ What concerns you the most about your problem? What does it prevent you from doing? \_\_\_\_\_

◆ What is your: Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

◆ How would you rate your overall health?  Excellent  Very Good  Good  Fair  Poor

◆ What type of exercise do you do on a regular basis?  Strenuous  Moderate  Light  None

◆ Family History: Place an (X) if any family member has suffered from:

- |   |                                   |   |  |  |
|---|-----------------------------------|---|--|--|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus          | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Heart Attacks       |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> ALS      | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Gout            | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Spinal Disorder | <input type="checkbox"/> Arthritis           |

◆ For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

PAST	PRESENT	PAST	PRESENT	PAST	PRESENT	PAST	PRESENT
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Neck Pain
<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains
<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Hip Pain
<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain
<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorders	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Tumor
<input type="checkbox"/>	<input type="checkbox"/> Muscular Coordination	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Other: _____				
For Females Only:		<input type="checkbox"/>	<input type="checkbox"/> Birth Control	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy

◆ What activities do you do at work?

- |                |  |                                       |  |
|----------------|--|---------------------------------------|--|
| Sit:           | <input type="checkbox"/> Most Of The Day | <input type="checkbox"/> Half The Day | <input type="checkbox"/> A Little Of The Day |
| Stand:         | <input type="checkbox"/> Most Of The Day | <input type="checkbox"/> Half The Day | <input type="checkbox"/> A Little Of The Day |
| Computer Work: | <input type="checkbox"/> Most Of The Day | <input type="checkbox"/> Half The Day | <input type="checkbox"/> A Little Of The Day |
| On The Phone:  | <input type="checkbox"/> Most Of The Day | <input type="checkbox"/> Half The Day | <input type="checkbox"/> A Little Of The Day |
| Driving:       | <input type="checkbox"/> Most Of The Day | <input type="checkbox"/> Half The Day | <input type="checkbox"/> A Little Of The Day |
| Manual Labor:  | <input type="checkbox"/> Most Of The Day | <input type="checkbox"/> Half The Day | <input type="checkbox"/> A Little Of The Day |

◆ What activities do you do outside of work? \_\_\_\_\_

◆ List all prescription medications you are currently taking: \_\_\_\_\_

◆ List all over-the-counter medications you are currently taking: \_\_\_\_\_

◆ List all surgical procedures you have had: \_\_\_\_\_

◆ Have you ever been hospitalized?  No  Yes  
If Yes, what were you hospitalized for? \_\_\_\_\_

◆ Have you seen a Chiropractor before?  No  Yes  
If Yes, who? \_\_\_\_\_ When was your last visit? \_\_\_\_\_

◆ Have you had any other significant past trauma?  No  Yes

◆ Anything else pertinent to your visit today? \_\_\_\_\_

I hereby authorize Sylvia Chiropractic Center to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payments, or make payment directly to me. First day's fees are due and payable at the time of service.  
BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. SYLVIA FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

\_\_\_\_\_  
Signature of Patient, or of Guardian authorizing care

\_\_\_\_\_  
Date

# SYLVIA CHIROPRACTIC CENTER

## ACTIVITIES OF DAILY LIVING

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

**Activities of Daily Living:** The things we normally do in daily living including any daily activity we perform for self-care (such as feeding ourselves, bathing, dressing, grooming), work, homemaking, and leisure. The ability or inability to perform ADL's can be used as a very practical measure of ability/disability in many disorders.

Please place a check beside any/all of the following activities that you are **having trouble performing** on a normal daily basis **without pain**.

\_\_\_ Dressing

\_\_\_ Bathing

\_\_\_ Lifting

\_\_\_ Grooming

\_\_\_ Walking

\_\_\_ Oral Care

\_\_\_ Sitting comfortably

\_\_\_ Toileting

\_\_\_ Sleeping through the night

\_\_\_ Climbing Stairs

\_\_\_ Having energy

\_\_\_ Eating

\_\_\_ Driving

\_\_\_ Shopping

\_\_\_ Reading

\_\_\_ Cooking

\_\_\_ Working

\_\_\_ Housework

\_\_\_ Running

\_\_\_ Doing Laundry

\_\_\_ Bending

\_\_\_ Playing with Children

OTHER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WELCOME**

**TO**

**SYLVIA CHIROPRACTIC**

**CENTER**

DO YOU HAVE A  
MEDICAL DOCTOR?

PLEASE CIRCLE

YES

NO