

**Ruck Spine and Sport**  
**Lawrence Ruck, D.C. 1 Neperan Road Tarrytown, NY 10591**  
 The following is a health history questionnaire. All information will be kept confidential.

Name: \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ Date of birth \_\_\_\_\_  
 \_\_\_\_\_ Sex: M F  
 Phone- Home: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Email address: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs.  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Primary care physician (name/location): \_\_\_\_\_ Last examination: \_\_\_\_\_  
 Emergency contact (name/number): \_\_\_\_\_  
 How did you hear about the office? \_\_\_\_\_  
 Marital status: S M W D Number of children: \_\_\_\_\_ Have you ever been treated by a chiropractor? yes  no

Briefly describe your present complaint(s) or injury:

\_\_\_\_\_

\_\_\_\_\_

Onset date of injury: \_\_\_\_\_ Have you had this before? yes  no  If yes, when? \_\_\_\_\_

Is your condition getting: better  worse  staying the same

The pain is: Constant  Intermittent

What aggravates your condition? \_\_\_\_\_

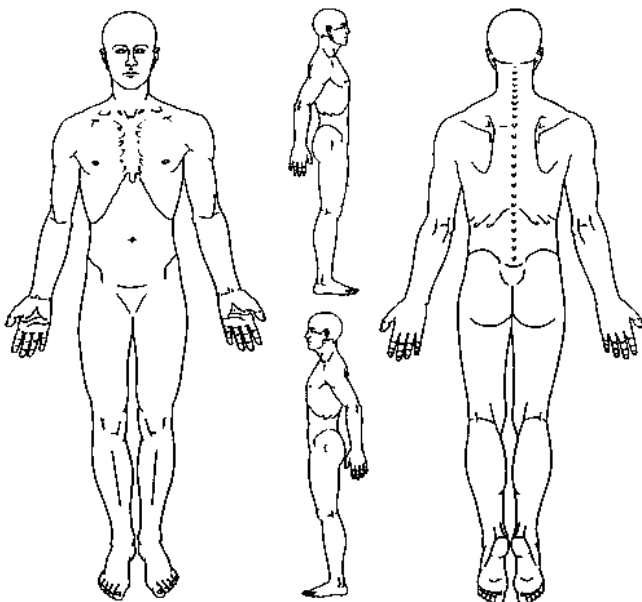
What relieves your condition? \_\_\_\_\_

Is there a time of day when your condition is worse? Morning  Afternoon  Evening  During the night

How would you describe your symptoms? (you may check more than one)

Sharp/shooting  Burning  Numbness/tingling  Dull/achy  Throbbing  Clicking  Weakness

**On the diagram below please indicate (with the appropriate letter) where you are experiencing pain.**



**A = Aching B = Burning N = Numbness**  
**S = Stabbing T = Tingling**

<u>Please circle your level of pain below</u>										
<u>Pain Currently</u>										
1	2	3	4	5	6	7	8	9	10	
<u>Pain at its worst</u>										
1	2	3	4	5	6	7	8	9	10	

**Are you currently experiencing any of the following (if yes, describe):**

Fatigue	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Chills	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Unexplained weight loss	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Night sweats	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Pain at night	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Fever	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Swollen glands	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Dizziness / vertigo	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Blurred or double vision	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Hearing loss	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Fainting	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Nausea or vomiting	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Loss of bowel / bladder control	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Abdominal pain	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Chest pain	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Shortness of breath	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Chronic cough	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Heartburn/GERD	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____

**Do you or an immediate family member have a history of any of the following? If yes, describe.**

Cancer	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Heart attack	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Heart disease	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Stroke	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Diabetes	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Arthritis	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____
Thyroid problems	no <input type="checkbox"/>	yes <input type="checkbox"/>	_____

Do you smoke tobacco? no  yes  If yes, how much per day? \_\_\_\_\_ packs/day for \_\_\_\_\_ years  
Do you drink alcohol? no  yes  If yes, how many drinks per week? \_\_\_\_\_  
Do you drink caffeinated beverages? no  yes  If yes, how many per day? \_\_\_\_\_

Please list medications, vitamins, and supplements:

Please list surgeries and hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What is your current exercise level?** None  Light/minimal  Moderate  Heavy/strenuous

**How many days per week do you exercise?** \_\_\_\_\_ days

**Do you participate in?** Cardio  Weight training  Sport  \_\_\_\_\_

**Please rate your nutrition as it relates to fitness/weight goals:** (0=very poor, 5=average, 10=excellent) \_\_\_\_\_

**Informed Consent:**

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures performed by Dr. Ruck. I understand that, as in the practice of traditional medicine, in the practice of chiropractic there are some risks to treatment including but not limited to disc injury, fractures/joint injury, and stroke. The possibility of such injuries are extremely rare. I do not expect Dr. Ruck to be able to anticipate all risks and complications and I wish to rely on the doctor's judgment during the course of the procedure which the doctor feels, at this time, based upon the facts then known, is in my best interest.

I have read and understand the above consent. I intend this consent to apply to all my present and future chiropractic care with Dr. Ruck.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_