# Chiropractic Office of Lawrence Ruck, D.C. CCSP

**200 South Broadway Suite 2-3 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 □

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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□

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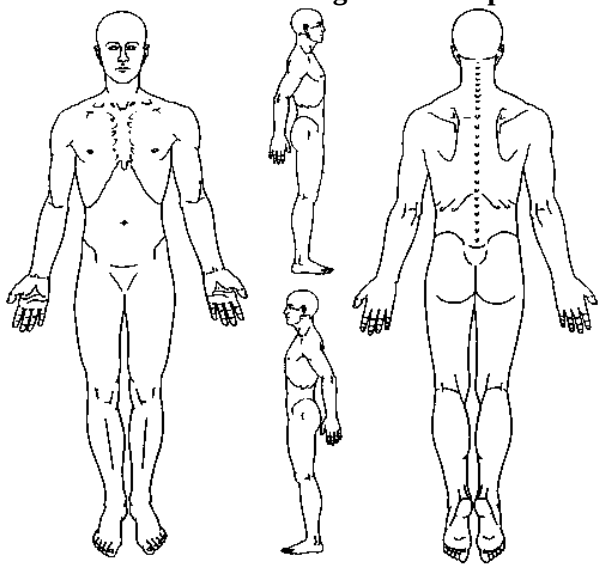
**On the diagram below please indicate where you are experiencing pain.**



Please circle your level of pain below

Pain Currently

1 2 3 4 5 6 7 8 9 10

Pain at its worst

1 2 3 4 5 6 7 8 9 10

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

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

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

| | | | |
|---|---|---|---|
| Cancer | no□ | yes□ | _____ |
| Heart attack | no□ | yes□ | _____ |
| Heart disease | no□ | yes□ | _____ |
| Stroke | no□ | yes□ | _____ |
| Diabetes | no□ | yes□ | _____ |
| Arthritis | no□ | yes□ | _____ |
| Thyroid problems | no□ | yes□ | _____ |

Do you use 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: _____