Dr. Andrea Czop D.C.
Dr. Andrew Mayberry D.C.
3157 Sugarloaf Parkway #130
Lawrenceville, Georgia 30044

Personal Information:

Name:_____ DOB:_____ Date:_____
Address:_____
City/State/Zip:_____
Home Phone #:_____Work Phone#:_____ Cell Phone #:_____
E-Mail:_____ Male_____Female_____
Best Time/# to Contact_____
Occupation:_____ Employer:_____
Single_____Married_____Divorced_____Widowed_____ No. of Children:_____
Names/Ages:_____
_____
Emergency Contact Person & Phone#_____

Who may we thank for referring you to our office?_____

Your Health Profile:

Why This Form Is Important

As a chiropractic office, we focus not only on normal aches and pains, but also on your ability to be healthy. Our goals are to first address the issues that brought you to this office, and second, to offer you the opportunity of improved wellness and quality of life in your future. On a daily basis, we all experience physical, biochemical, and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious.

Answering the following questions will give us a profile of the specific stresses, both past and present, that you've experienced and allow us to better assess the challenges to your health potential, as well as address what brought you to this office.

Please answer the questions below about your specific complaint(s) to the best of your ability. If you are only here for **wellness and preventative care, please skip to the next page**.

Primary Complaint	**Secondary Complaint**	**Tertiary Complaint**
Briefly describe complaint: _____ _____ _____	Briefly describe complaint : _____ _____ _____	Briefly describe complaint : _____ _____ _____
PAIN SCALE (CIRCLE) BEST WORST 0 1 2 3 4 5 6 7 8 9 10	PAIN SCALE (CIRCLE) BEST WORST 0 1 2 3 4 5 6 7 8 9 10	PAIN SCALE (CIRCLE) BEST WORST 0 1 2 3 4 5 6 7 8 9 10
Is it constant? ☐ Yes ☐ No Comes & goes? ☐ Yes ☐ No	Is it constant? ☐ Yes ☐ No Comes & goes? ☐ Yes ☐ No	Is it constant? ☐ Yes ☐ No Comes & goes? ☐ Yes ☐ No
Please check ALL that describe your current symptoms? ☐ Sharp ☐ Pins/Needles ☐ Stabbing ☐ Tingling ☐ Dull ☐ Numbness ☐ Aching ☐ Tightness ☐ Pinching ☐ Other	Please check ALL that describe your current symptoms? ☐ Sharp ☐ Pins/Needles ☐ Stabbing ☐ Tingling ☐ Dull ☐ Numbness ☐ Aching ☐ Tightness ☐ Pinching ☐ Other	Please check ALL that describe your current symptoms? ☐ Sharp ☐ Pins/Needles ☐ Stabbing ☐ Tingling ☐ Dull ☐ Numbness ☐ Aching ☐ Tightness ☐ Pinching ☐ Other
Please check ALL that aggravate your condition? ☐ Driving ☐ Breathing ☐ Walking ☐ Coughing ☐ Sitting ☐ Sleeping ☐ Bending ☐ Working ☐ Standing ☐ Exercising ☐ Bowel Movements ☐ Other	Please check ALL that aggravate your condition? ☐ Driving ☐ Breathing ☐ Walking ☐ Coughing ☐ Sitting ☐ Sleeping ☐ Bending ☐ Working ☐ Standing ☐ Exercising ☐ Bowel Movements ☐ Other	Please check ALL that aggravate your condition? ☐ Driving ☐ Breathing ☐ Walking ☐ Coughing ☐ Sitting ☐ Sleeping ☐ Bending ☐ Working ☐ Standing ☐ Exercising ☐ Bowel Movements ☐ Other
What makes your condition better? ☐ Chiropractic ☐ Stretching ☐ Rest ☐ Massage ☐ Recumbent ☐ Medication ☐ Sitting ☐ Nothing ☐ Standing ☐ Other	What makes your condition better? ☐ Chiropractic ☐ Stretching ☐ Rest ☐ Massage ☐ Recumbent ☐ Medication ☐ Sitting ☐ Nothing ☐ Standing ☐ Other	What makes your condition better? ☐ Chiropractic ☐ Stretching ☐ Rest ☐ Massage ☐ Recumbent ☐ Medication ☐ Sitting ☐ Nothing ☐ Standing ☐ Other
Have you had this current complaint in the past? ☐ Yes ☐ No If Yes, when? ____/ ____/ _____	Have you had this current complaint in the past? ☐ Yes ☐ No If Yes, when? ____/ ____/ _____	Have you had this current complaint in the past? ☐ Yes ☐ No If Yes, when? ____/ ____/ _____
Have you seen any other healthcare providers for your current complaint? ☐ Yes ☐ No	Have you seen any other healthcare providers for your current complaint? ☐ Yes ☐ No	Have you seen any other healthcare providers for your current complaint? ☐ Yes ☐ No

Additional Notes:_____

_____

_____

Personal History Survey: Please circle any of the following conditions you have or have had in the past, even though they may not seem relevant to your current issues.

C = current P = past If **none** of the below apply please check this box ☐

MUSCLE /JOINT	C	P
Arthritis	C	P
Back Pain	C	P
Sciatic Pain	C	P
Bursitis	C	P
Hip Pain	C	P
Foot Pain	C	P
Neck Pain	C	P
Headache	C	P
Shoulder Pain	C	P
Arm Pain	C	P
Wrist Pain	C	P

EYES/EARS/THROAT	C	P
Thyroid	C	P
Hearing Difficulty	C	P
Vision	C	P
DIGESTIVE	C	P
Stomach	C	P
Intestinal	C	P
Colon	C	P
INTERNAL	C	P
Liver	C	P
Gall bladder	C	P
Pancreas	C	P

SKIN	C	P
Easy Bruising	C	P
Psoriasis/ Eczema	C	P
Hives	C	P
Skin Allergy	C	P
Itching	C	P
Varicose	C	P
PULMONARY	C	P
Difficulty Breathing	C	P
COPD	C	P
Asthma	C	P
Seasonal Allergy	C	P

CARDIOVASCULAR	C	P
Blood Pressure	C	P
Irregular Heart Beat	C	P
Poor Circulation	C	P
URINARY	C	P
Kidney	C	P
Difficulty Urinating	C	P
REPRODUCTIVE	C	P
Menstrual	C	P
Pregnancy	C	P
Prostate	C	P
Venereal Disease	C	P

GENERAL	C	P
Food Allergy	C	P
Dizziness	C	P
Infections	C	P
INFECTIOUS DISEASES	C	P
HIV	C	P
Hepatitis	C	P
Tuberculosis	C	P
ENDOCRINE	C	P
NEUROLOGICAL	C	P
PSYCHOLOGICAL	C	P

Please list all of the medications you are taking including over the counter medications, herbs & vitamins and nutritional supplements. *If none please write:* ***None***

Name / Dose / Frequency

_____

_____

_____

_____

Name / Dose / Frequency

_____

_____

_____

_____

Medication Allergies - Please list all below _____

_____

Please list ALL accidents, injuries, surgeries & hospitalizations. *If none please write:* ***None***

Accidents, Injuries, Fractures (Dates) _____

_____

Surgeries (Dates**)** _____

_____

Hospitalizations (Dates) _____

_____

Please list all of your doctors and healthcare providers including previous Chiropractors

Name: _____ Phone # _____

Name: _____ Phone # _____

Name: _____ Phone # _____

Health Habits & Lifestyle:

EXERCISE

Do you exercise?
☐ Yes ☐ No

How often do you exercise?
___ days/week ___ Hours/day

Stretching / Flexibility
☐ Yes ☐ No

Running / Treadmill/ Walking
☐ Yes ☐ No

Rowing / Swimming
☐ Yes ☐ No

Competitive Athlete
☐ Yes ☐ No

Pilates /Yoga ☐ Yes ☐ No

Group Exercise ☐ Yes ☐ No

Weight Lifting ☐ Yes ☐ No

OTHER: Please list-

_____

_____

_____

DIET

Do you have a healthy diet?
☐ Yes ☐ No

How many serving s of fruits & vegetables per day? # _____

How many 8oz. glasses of water per day? # _____

Do you drink caffeinated beverages? ☐ Yes ☐ No

How many per day? # _____

Please List Food Allergies?

_____

_____

Have you ever had an eating disorder? ☐ Yes ☐ No

ALCOHOL/TOBACCO/RECREATIONAL DRUG USE?

Do you use any of the above?
☐ Yes ☐ No

How many cigarettes do you smoke?

_____ /day or _____/wk

Do you use smokeless tobacco?
☐ Yes ☐ No

How much do you use a day?

Cans or pouches _____ /day

Do you have history of alcohol use?
☐ Yes ☐ No

drinks ____ /day _____ /wk

1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor, 80 proof, 5 oz. wine.

DAILY STRESS LEVEL SCALE

Low High
0 1 2 3 4 5 6 7 8 9 10

Have you ever sought help for a mental health issue?
☐ Yes ☐ No

SLEEPING PATTERN

Hours of sleep per night? _____ hours

Please circle appropriate sleep quality.

Excellent Good Fair Poor

Sleep interrupted _____ X/ night

How long? ___ wks, ___ months, ___ years

Family History:

Family History Please mark the appropriate box with an X. If **none** of the below please check this box ☐

HISTORY	Mother	Father	Brother/Sister	Grandmother	Grandfather
Diabetes	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Auto immune Disorder	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

I hereby consent to a professional and complete chiropractic examination and to any radiographic(x-ray) examination the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Name:_____ **Signature**:_____ **Date**:_____