Michelle S. Rose, D. C. **Green Run Chiropractic**

1190 Lynnhaven Pkwy.
Virginia Beach, VA 23452
757-468-5444

Last Name:______________________ First:______________________ MI:______

Address:____

SSN: ______________ Home Phone: ______________ Cell: ______________ Birthday: ______________

Employer: ______________ Address: ______________ Work Phone: ______________

Spouse's Name: ______________ Email:______________

Who's responsible for this bill?: □Myself □Spouse □Parent □Insurance □Medicare □Auto □Work Comp □Other

Who were you referred by:____

What is your major complaint?: ____

____

____

Rate your pain on a scale of 1 to 10: (none) 1 2 3 4 5 6 7 8 9 10 (severe). Date of injury/ onset: ______________

Was the onset of pain: □Sudden □Gradual? Have you had this pain before? Y N Is the pain: □Worse □mproving □Unchanged?

Describe your pain/ symptoms: □Dull □Achy □Stiff □Sharp □Shooting □Numb □Tingling □Burning □Weakness □Cramping □Constant □Coming & Going □Other:______________

What makes your pain/ symptoms better?______________

What makes your pain/ symptoms worse?______________

Does the pain restrict your daily activities? Y N If yes, describe:______________

Was this an auto or work– related accident? Y N If yes, describe:______________

Please list any medications you are now taking (include over the counter medicine): □None ______________

____

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 10 YEARS:

□Neck Problems	□Allergies	□Cancer
□Shoulder Problems	□Asthma	□Hemorrhoids
□Lower Back Pain	□Sinus Problems	□Weight Trouble
□Pain btw./ in Shoulders	□Lung/ Breathing Problems	□Skin Problems
□Walking Problems	□Chest Pain	□Thyroid Problems
□Arm/ Hand Pain	□High Blood Pressure	□Kidney Problems
□Leg/ Foot Pain	□Heart Disease/ Problems	□Ulcers
□Loss of Equilibrium/ Balance	□Diabetes	□Constipation
□Loss of Feeling	□Sleep Disturbances	□Prostrate Problems
□Stiff or Painful Joints	□Depression	□Frequent Colds/ Illnesses
□Muscle Cramps/ Spasms	□Female Issues	□Vision Problems
□Headaches	□Nausea	□Dizziness/ Vertigo
□Forgetfulness	□Fainting	□Hearing Loss
□Tiredness/ Fatigue	□Tinnitus (ringing in ears)	□ Poor Digestion
□Numbness/ Tingling	□Ear Infections	□Gastrointestinal Problems
□Broken Bones	□Jaw/ TMJ Pain	□Urinary Problems
□Sprains/Strains	□Difficulty Swallowing	□Excessive Thirst

Are You Pregnant? □Yes □No Date of Last Menstrual Cycle ______________

Please list and describe any of the following:

1. Car Accidents:______________
2. Falls/ Injuries (including sports):______________
3. Other Traumas:______________

Names of Doctors (MD):______________

Have you ever had surgery or been hospitalized? □Yes □No If yes, describe______________

____

____

Have you ever had Chiropractic care before? □Yes □No Name of Chiropractor:______________

Describe significant family history:______________

____

Do you grant GRC permission to contact your doctors regarding your care here? □Yes □No

Patient's Signature:______________ **Date**:______________