

Life is great...



Chiropractic Care makes it better.

Delmar Office
2 Normanskill, Blvd. Delmar,
NY 12054

M- W-F By Appointment

Dr. Robert S. Golden

Over 30 years providing chiropractic
care tailored to your needs

518-439-3189

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WELCOME

REASON FOR VISIT

Reason for today's visit: Emergency New injury Old injury Chronic pain Wellness

Are you in pain: Yes No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Did your injury occur during: Work Sports/play Auto Accident Routine/Household activity

When did your condition/accident occur? ___ / ___ / ___ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes.

Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Has this or something similar happened in the past?

Yes No Explain: _____

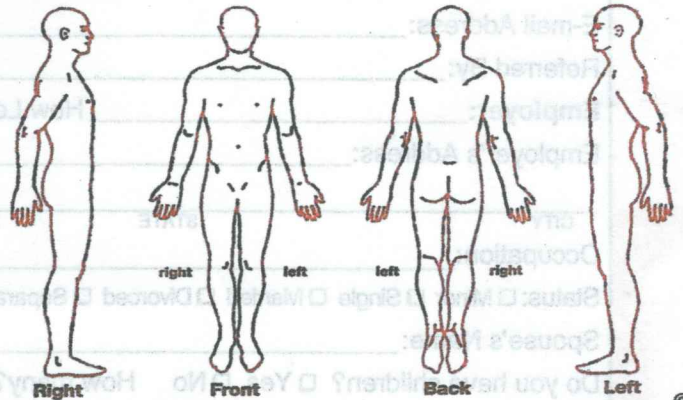
Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? Yes No If so, where? _____

Have you ever been treated by a Chiropractor? Yes No

Clinic or Dr's name: _____

Clinic phone#: _____



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HEALTH HISTORY

Are you taking any of the following medications? Nerve pills Pain killers(including aspirin) Muscle relaxers

Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|-----------------------------|--------------------------------|-------------------------|--------------------------------------|---------------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N HIV+ / AIDS / ARC |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Anemia / Diabetes |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Severe / Frequent Headaches | Y N Kidney Problems |
| Y N Ulcers / Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema / Asthma | Y N Tuberculosis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N Arthritis |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: ___ / ___ / ___

For woman: Are you taking Birth Control? Yes No Are you taking Hormonal Replacement? Yes No

Are you Nursing? Yes No Are you Pregnant? No Yes If so, how many weeks? _____

