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Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex M/F

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_Marital S M D W

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present condition due to an injury? \_\_Yes \_\_ No \_\_on the job \_\_auto accident \_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the accident been reported? \_\_ Yes \_\_ No \_\_ to employer \_\_ auto carrier \_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other doctors seen for this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any diagnosis and type of treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received chiropractic treatment previously? \_\_Yes \_\_ No

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? \_\_ Yes \_\_ No

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking medication? \_\_ Yes \_\_ No List medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

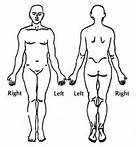
List conditions you are taking medications for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the approximate dates of any surgery or treated conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you smoke Y/N Alcohol Y/N Caffeinated drinks per day \_\_\_\_\_ Do you take vitamins/supplements?

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

 Please circle degree of pain, 0 none, 10 severe pain

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where

You feel pain.

Numbness =====

Dull Ache OOOO

Burning XXXXX

Sharp/Stabbing //////

Pins, Needles +++++

Other ^^^^^

What activities aggravate your condition/pain?\_\_\_\_\_\_\_

What activities lessen your condition/pain?\_\_\_\_\_\_\_\_\_\_

Is this condition worse during certain times of the day?

Is this condition interfering with Work? \_\_\_\_\_\_\_\_\_\_\_\_

Sleep? \_\_\_\_\_\_\_ Routine? \_\_\_\_\_\_\_\_ Other? \_\_\_\_\_\_\_\_\_

Is this condition progressively getting worse? \_\_\_\_\_\_\_\_

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