



Staci Talan, D.C., I.D.E., Q.M.E.

Chiropractor * Industrial Disability Examiner (IDE) * Qualified Medical Examiner (QME)

39809 Paseo Padre Parkway, Fremont, CA 94538 * TEL: 510-657-1234 * FAX: 510-657-1233

Chief complaint or reason for today's visit? _____

How long have you had this condition? _____ Date of Onset? _____

Have you had this condition before? _____ If yes, when? _____

Is the condition related to Work () Auto () Date of Accident: _____ Have you lost days at work? _____

What doctors have seen you for this condition? _____ Diagnosis _____

Provide dates of last: Xray: _____ Physical Examination: _____ Blood Test: _____

Name of primary treating physician: _____

Height _____ Weight _____ Age _____ Occupation _____

Do you smoke? no yes If, yes how many packs/day _____ Do you drink Alcohol? no yes

If yes how many drinks a day _____ Do you drink coffee? no yes If yes how many cups a day _____

Have you seen a Chiropractor? Yes () No () Who: _____ Did it help? Yes () No ()

PROBLEM AREA #1

The pain is located _____ The pain started _____ days ago _____

weeks ago _____ months ago _____ years ago _____

On a scale of 1-10 rate your pain No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How would you describe the pain dull, achy sharp, stabbing burning pins and needles

Do you consider this problem to be severe? yes yes, at times no

The pain is made *better* by _____

The pain is made *worse* by _____

The pain is (as far as timing is concerned: i.e: comes & goes, constant etc.) _____

There is radiating pain, tingling, or numbness into _____

How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

How much has the problem intefered with your social activities?

Not at all A little bit Moderately Quite a bit Extremely

ADDITIONAL AREA #2

The pain is located _____

The pain started _____ days ago _____ weeks ago _____ months ago _____ years ago



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On a scale of 1-10 rate your pain No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How would you describe the pain dull, achy sharp, stabbing burning pins and needles

The pain is made *better* by _____

The pain is made *worse* by _____

The pain is (as far as timing is concerned: i.e: comes & goes, constant etc.) _____

There is radiating pain, tingling, or numbness into _____

ADDITIONAL AREA #3

The pain is located _____ The pain started _____

days ago _____ weeks ago _____ months ago _____ years ago _____

On a scale of 1-10 rate your pain No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How would you describe the pain dull, achy sharp, stabbing burning pins and needles

The pain is made *better* by _____

The pain is made *worse* by _____

The pain is (as far as timing is concerned: i.e: comes & goes, constant etc.) _____

There is radiating pain, tingling, or numbness info _____

How would you rate your overall Health? Excellent Very Good Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
- Heart Problems Cancer ALS

List all prescription medications you are currently taking: _____

List all supplements, vitamins and herbs you are currently taking: _____

List all surgical procedures you have had: _____

What activities do you do at work?

<input type="checkbox"/> Sit	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer Work	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Light Labor	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day



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What activities do you do outside of work? _____

Have you ever been hospitalized? _____

Have you had a significant trauma in the past? _____

Anything else pertinent to your visit today? _____

For each of the conditions listed below, place a check in the “past” column if you have had the condition in the past. If you presently have a condition listed below, place a check in the “present” column.

Past/Present		
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> <input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Use
<input type="checkbox"/> <input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> <input type="checkbox"/> Bladder Infection	<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> Wrist Pain	<input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> <input type="checkbox"/> Hand Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Hip Pain	<input type="checkbox"/> <input type="checkbox"/> Prostate Problems	<input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/> <input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> <input type="checkbox"/> Abnormal Wt. Gain/Loss	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> <input type="checkbox"/> Knee Pain	<input type="checkbox"/> <input type="checkbox"/> Loss Of Appetite	<input type="checkbox"/> <input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Cond	<input type="checkbox"/> <input type="checkbox"/> General Fatigue
<input type="checkbox"/> <input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> <input type="checkbox"/> Dizziness
<input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> <input type="checkbox"/> Other: _____	

For female use:

<input type="checkbox"/> <input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement	<input type="checkbox"/> <input type="checkbox"/> Pregnancy: #: _____
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Patient Signature: _____ Date: _____