



Robek Chiropractic &
Sports Rehabilitation
Center

Patient Information

Date _____
 SS# _____ - _____ - _____
 First Name: _____ Last Name: _____
 Address _____

 City _____
 State _____ Zip _____
 E-mail _____
 Sex M F Age _____ Birth date ____/____/____

Employment Information

Occupation _____
 Employer/School _____
 Work Phone (_____) _____ ext. _____

Phone Numbers

Home (_____) _____ Cell (_____) _____
 Best time and place to reach you _____

In Case of Emergency, Contact...

Name _____ Relationship _____
 Home (_____) _____ Work/Cell (_____) _____

How did you hear about our office? _____

Patient Condition

Reason for Visit _____

When did your symptoms appear and what happened to cause them? _____

Is this condition getting progressively worse? Yes No Unknown
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

- Sharp Dull Throbbing Numbness Aching Shooting
- Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____
 Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Recreation Daily Routine

Activities or movements which are painful to perform:

- Sitting Standing Walking Bending Lying Down

What Treatment have you already received for your condition: Medication Surgery
 Physical Therapy Chiropractic Services None Other: _____

Previous Injuries/Accidents that could be related to your current symptoms.

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bone	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Place a mark on "Yes" or "No" to indicate if you have or have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prostate Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Others:	_____		

Exercise:	Work Activity:	Habits:	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day: _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/week: _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine,	Cups/Day: _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stess Level,	Reason: _____

Are you pregnant? Yes No Due Date: _____