Wayne M. Winnick, DC, CCSP and Associates, PC

Full Name:_____ D.O.B._____

Address:_____City:_____St:_____ Zip:_____

Home Phone:_____ Cell #:_____ Age:_____

Work Phone:_____ Social Security #:_____

Occupation:_____ Employer:_____

☐Male ☐Female Height: _____ Weight:_____ E-mail:_____

☐Single ☐Married ☐Widowed ☐Divorced ☐Separated Number of Children_____

Spouse's Name:_____

Spouse's Occupation:_____ Employer:_____

Emergency Contact:_____ Phone #:_____

Insurance Name:_____

Who Referred You To Our Office:_____

Purpose of this Appointment:_____

Other Doctors Seen for this Condition: ☐Yes ☐No Who:_____

Type Of Treatment:_____ RESULTS:_____

When Did this Condition Begin?:_____ Has This Condition Occurred Before? ☐Yes ☐No

Is Condition: ☐Sports Related ☐Chronic ☐Home Injury ☐Fall ☐Other/Auto:_____

Drugs You Now Take: ☐Nerve Pill ☐Pain Killers ☐Muscle Relaxers ☐Blood Pressure ☐Insulin
☐Drug Interactions/Allergies _____

Do You Wear Arch Supports or Orthotics? ☐Yes ☐No

Do You Suffer From Any Other Condition Than The One You Are Now Consulting Us For?_____

Major Surgery or Operations: ☐Appendectomy ☐Tonsillectomy ☐Hernia ☐Gallbladder
☐Back Surgery ☐Broken Bones ☐Other:_____

Major Accidents of Falls or Hospitalization Other Than Above:_____

Have You Ever Had Chiropractic Care Before? ☐Yes ☐ No

If Yes, Date of Last Visit:_____Doctor's Name: _____

Check Any of the Following you Have Had in the Past 2 Months

Head
- ☐ Headaches
- ☐ Migraine
- ☐ Head Feels Heavy
- ☐ Fainting
- ☐ Dizziness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Loss of Balance
- ☐ Loss of Hearing
- ☐ Ringing in ears
- ☐ Jaw pain
- ☐ Clicking jaw

Neck
- ☐ Pain in neck
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck

Shoulders
- ☐ Pain in shoulder
- ☐ Pain across shoulders
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders

Arms & Hands
- ☐ Pain in arm (R--L)
- ☐ Pain in hands (R -- L)
- ☐ Pain in fingers (R -- L)
- ☐ Sensations of pins & needles
  - ☐ in hands (R -- L)
  - ☐ in arms (R -- L)
  - ☐ fingers go to sleep (R -- L)
- ☐ Hands cold (R -- L)
- ☐ Swollen/sore/finger joints (R -- L)
- ☐ Loss of grip strength (R -- L)

Mid-back:
- ☐ Mid back pain
- ☐ Muscle spasms
- ☐ Pain with breathing

Chest:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Heart palpitation

Abdomen:
- ☐ IBS
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers

Low-Back:
- ☐ Low back pain

Low back pain is worse when:
- ☐ working
- ☐ lifting
- ☐ stooping
- ☐ standing
- ☐ sitting
- ☐ bending
- ☐ coughing

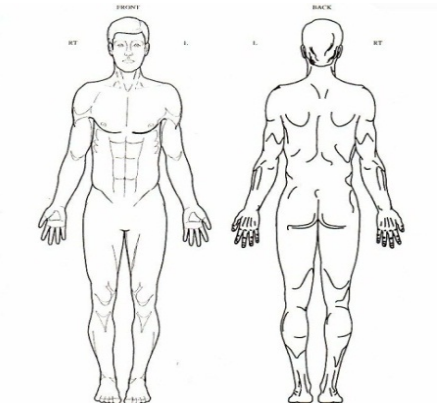
- ☐ Disc conditions
- ☐ Muscle spasm

Women Only:
- ☐ menstrual pain
- ☐ cramping
- ☐ Pregnant: ☐ yes ☐ no

Hip, Legs & Feet:
- ☐ Pain in buttock (R -- L)
- ☐ pain in hip joint (R -- L)
  - ☐ groin (R -- L)
- ☐ Pain in back of thigh (R -- L)
  - ☐ numbness (R -- L)
  - ☐ tightness (R -- L)
- ☐ Pain down to the leg(s) (R -- L)
- ☐ Pins & Needles in legs (R -- L)
- ☐ Cramps in feet (R -- L)
- ☐ Painful joint in toes (R -- L)

General
- ☐ AIDS/HIV
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Depressed
- ☐ Generally feel run-down
- ☐ Lack of sleep
- ☐ Heart attacks
- ☐ Blood pressure problems
- ☐ Stroke
- ☐ Difficulty with urination
- ☐ Incontinence
- ☐ Asthma
- ☐ Allergies
- ☐ Epilepsy
- ☐ Gall Bladder Problems
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Cancer
- ☐ Stress

Please outline on the diagram the area of your discomfort



I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance.If it becomes necessary to effect collections of any amount on this or subsequent visits the undersignes agrees to pay for all cost & expenses includingreasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature_____

Date_____