Center for Chiropractic & Pain Rehabilitation ● **3241 NE Broadway Street● Portland, Oregon 97232**
TEL :(503) 282-8582 FAX: (503) 460-0814

Dr. Peter G. Macris

Today's Date: ____-____-______

Patient Name: ____________________________ Age: ___ Date of Birth: ____-____-______ Sex: ____
Home Phone: (____) ________________ Work Phone: (____) __________________

REASON(s) FOR SEEKING CHIROPRACTIC CARE NOW:

1. ____
2. ____
3. ____

2. Please circle the quality of your current pain or symptoms now: Sharp/ stabbing/ shooting; burning; electrical; achy; dull; soreness; numbness; tingling; weakness; throbbing; gnawing; gripping/constricting.

3. How often are the complaints present? Please circle one: Constant (76 – 100%) Frequent (51- 75%) Occasional (26 – 50%) Intermittent (≤ 25%).

4. Is it different depending on the time of day i.e., worse or better in the morning or evening?

5. Indicate (by circling one) the status of your pain / condition: increasing decreasing staying the same?

6. Indicate the severity of your pain or symptoms by circling a number (0 = none, 10 = worst imaginable):
0 1 2 3 4 5 6 7 8 9 10

7. When did you first notice this problem, and/or how long has it been going on? ____________________________
____

8. Please describe how your problem or condition began. ____
____

9. What treatment (if any) have you received for this condition?____
____

Please circle the appropriate answer to the following questions:

10. Have you ever been treated for this condition before and by whom: YES______ NO ______ if yes, by: MD, DC, PT, LMT, OTHER (please indicate) ____________________________________ City______________________ State________________________

11. Does anything make your problem better? Nothing/inactivity lying down walking standing sitting movement

12. Does anything make your problem worse? Nothing/inactivity lying down walking standing sitting movement

13. Are you now, or have you had any of these symptoms: Numbness; Tingling; Weakness? If so, please describe where (If at all) it is happening ____

14. Please indicate your general stress level: None Minimally Moderately Severely

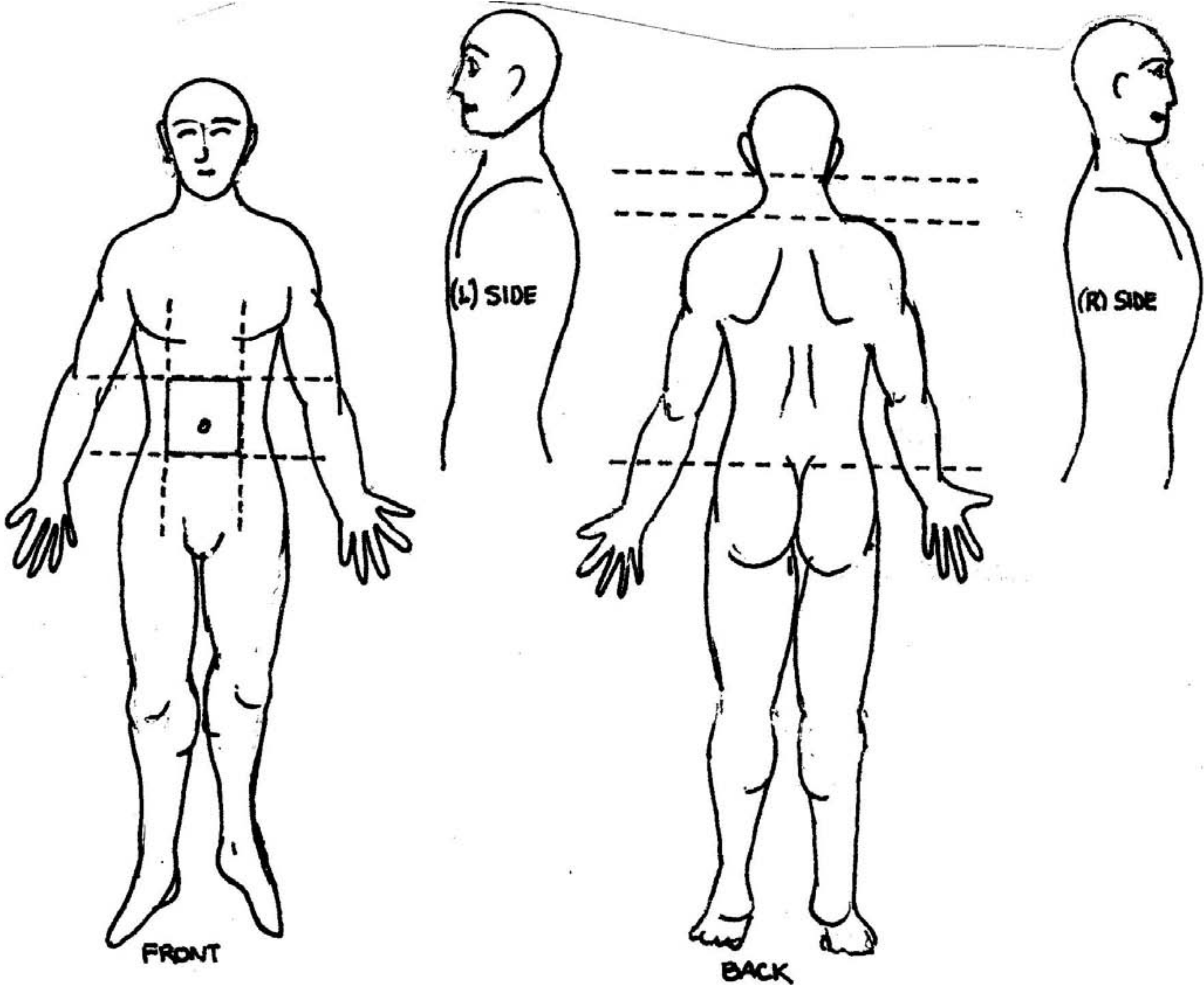
15. Indicate your level of physical activity at work: Sedentary ≥50% if the time Light. Manual labor Heavy Manual labor

16. General level of physical activity: No regular exercise program Light exercise program Strenuous exercise program

(Continued on the back of this form)

17. Is this problem/condition affecting you ability to work or otherwise function? (Check the appropriate box)
    - □ No effect
    - □ I need limited assistance, with ordinary activities of daily living
    - □ I often need assistance, with ordinary activities of daily living
    - □ I have significant need of assistance, performing ordinary activities of daily living
    - □ I am totally disabled

PLEASE CIRCLE THE AREA(s) WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Center for Chiropractic and Pain Rehabilitation ● 3241 NE Broadway Street ● Portland, Oregon 97232 ● (503)282-8582
Dr. Peter G. Macris

PERSONAL HEALTH HISTORY

Patient's Name ____________________ **DOB** ______________ **Clinician** ______________________________ **Date** ___________

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Cramps (describe where)
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain, stiffness
☐ ☐ ☐ Pain in the legs/feet
☐ ☐ ☐ Pain between shoulders
☐ ☐ ☐ Painful/stiff/swollen joints
☐ ☐ ☐ Weakness / soreness

General
☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting spells
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of balance
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness, depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

Cardiovascular
☐ ☐ ☐ Fluttering or pounding
☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Murmurs
☐ ☐ ☐ Pain on exertion
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Palpitations
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heartbeat
☐ ☐ ☐ Sitting up to breath
☐ ☐ ☐ Slow heartbeat
☐ ☐ ☐ Swollen ankles/feet

Genitourinary
☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Bloody/dark urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Lack of kidney control
☐ ☐ ☐ Kidney infection
☐ ☐ ☐ Kidney stones
☐ ☐ ☐ Painful/burning urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus/discharge in urine
☐ ☐ ☐ Slow urine stream
☐ ☐ ☐ Urinary incontinence

Eye, Ear, Nose and Throat
☐ ☐ ☐ Asthma

O F C

Eye, Ear, Nose and Throat
☐ ☐ ☐ Blind spots
☐ ☐ ☐ Blurred vision
☐ ☐ ☐ Colds (frequent)
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Dentures
☐ ☐ ☐ Double vision
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noise/ringing
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum/lip trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hearing loss
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Mastoid Problems
☐ ☐ ☐ Nasal discharge
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nose bleeds
☐ ☐ ☐ Post nasal drip
☐ ☐ ☐ Sinus congestion
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Excess sneezing
☐ ☐ ☐ Sore throat (freq.)
☐ ☐ ☐ Tonsillitis
☐ ☐ ☐ Wear glasses
☐ ☐ ☐ Wear contacts

Gastrointestinal
☐ ☐ ☐ Anal itching
☐ ☐ ☐ Antacid use
☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Black or Tarry stool
☐ ☐ ☐ Bloated abdomen
☐ ☐ ☐ Blood in the stool
☐ ☐ ☐ Bowel Movements
#/day______
☐ ☐ ☐ Change in bowels
☐ ☐ ☐ Colitis (Ulcerative)
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Bloated abdomen
☐ ☐ ☐ Crohn's disease
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gallbladder trouble
☐ ☐ ☐ Heartburn
☐ ☐ ☐ Hemorrhoids / Piles
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Laxitive use
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea

O F C

Gastrointestinal (cont.)
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Trouble swallowing
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

Skin
☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Excessive moisture
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Poor healing
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Sore skin (chronic)
☐ ☐ ☐ Varicose veins

Pain or numbness in
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Neck (including swelling)
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hand
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tailbone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal curvature
☐ ☐ ☐ Swollen joints

Respiratory
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficultly breathing
☐ ☐ ☐ Excessive mucous/pus
☐ ☐ ☐ History of Pleurisy
☐ ☐ ☐ Shortness of breath
☐ ☐ ☐ Spitting/coughing blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Trouble getting breath
☐ ☐ ☐ Wheezing

Women only
☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excess menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Lumps in breast
☐ ☐ ☐ Menopause/ Hot flashes
☐ ☐ ☐ Menstrual pain/tension
☐ ☐ ☐ Post menopausal blood
☐ ☐ ☐ Vaginal discharge
☐ ☐ ☐ Vaginal dryness
☐ ☐ ☐ Bleeding between periods
☐ ☐ ☐ Excess menstrual blood

Menstrual
Age at Menarche?___
Date of last period ___
Ave. duration of flow___
Last PAP: ____ result:___
Pads or Tampons? ___

Contraception: __YES__NO
HRT: ____YES____NO
Dates of use__________

Pregnancy Info
Pregnant now? ☐Yes ☐No
If yes, # of months?__
# of own children? ___
# of live births___
# of Miscarriages___
# of abortions ___
of "C" sections ___
of premature births ___
Complications? _______

Sex/Sexual Function
Y / N
☐ ☐ Satisfaction with
☐ ☐ Frequency of
☐ ☐ Performance of
☐ ☐ Painful
Other? ____________

Mood
Y / N
☐ ☐ Generally happy?
☐ ☐ Lack of memory?
☐ ☐ Crying often?
☐ ☐ Often depressed?
☐ ☐ Often irritable?
☐ ☐ Worried a lot?
☐ ☐ Easily upset?
☐ ☐ Feeling overwhelmed?
☐ ☐ Under a lot of stress
☐ ☐ Overly shy or sensitive?
☐ ☐ Problems at work?
☐ ☐ Problems at home?
☐ ☐ Frightening thoughts?
☐ ☐ Desire Psychiatric help?
☐ ☐ Considered suicide?

Neurologic (where, etc.)
Chronic pain_________
Numbness __________
Tingling ___________
Weakness ___________
Loss of sensation ______
Burning ____________
Fainting/L.O.C._________
Paralysis ___________
Tremor/Trembling ______
Seizures ____________
Poor/loss of balance ____

Center for Chiropractic and Pain Rehabilitation ● 3241 NE Broadway Street ● Portland, Oregon 97232 ● (503)282-8582
Dr. Peter G. Macris

Check any of the following conditions you currently have or have had:

☐ AIDS	☐ Alcoholism	☐ Anemia
☐ Appendicitis	☐ Arteriosclerosis	☐ Abdominal aneurism
☐ Cancer	☐ Chicken pox	☐ Cholera
☐ Cold sores	☐ COPD	☐ Deep Vein Thrombosis (DVT)
☐ Diabetes	☐ Diphtheria	☐ Dislocations / Sprains
☐ Eczema	☐ Edema	☐ Emphysema
☐ Epilepsy	☐ Extensive burns	☐ Fever blisters
☐ Fibromyalgia	☐ Goiter	☐ Gout
☐ Heart attack (MI) /disease	☐ Hepatitis/Liver disease	☐ Herpes
☐ HIV	☐ Influenza	☐ Intestinal disease
☐ Kidney disease	☐ Lumbago / Back Injury	☐ Lupus Erythematosis
☐ Lyme disease	☐ Malaria	☐ Measles (3-day)
☐ Migraine headaches	☐ Miscarriage	☐ Mononucleosis
☐ Multiple sclerosis	☐ Mumps	☐ Myasthenia Gravis
☐ Nervous system disease	☐ Osteoporosis	☐ Pacemaker
☐ Pleurisy	☐ Polio	☐ Pneumonia
☐ Radiation exposure	☐ Rheumatic fever	☐ Rheumatoid Arthritis
☐ Scarlet fever	☐ Scleroderma	☐ Shingles (**active**)
☐ Stroke	☐ Thyroid disease	☐ Tropical disease (Malaria, etc.)
☐ Tuberculosis (active)	☐ Typhoid fever	☐ Ulcers (Skin/Dermis)
☐ Ulcers (Stomach or Duodenal)	☐ Venereal disease	☐ Whooping cough

Describe chiropractic problem:______________________________

Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please specify)
What seemed to be the initial cause?
Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? ________ For what reason?
Are you under the care of another physician? ☐ Yes ☐ No If yes, for what reason?

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No for serious injury? ☐ Yes ☐ No Please indicate dates of any surgeries:
Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?
Indicate any of these drugs, you take currently? ☐ Birth control pills ☐ Tranquilizers ☐ Pain Killers ☐ Other (specify)
Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes?
What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable? Do you use a bedboard? ☐ Yes ☐ No
How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify)

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	
- been hospitalized?	☐	☐	
- had strains or sprains?	☐	☐	
- used a cane, crutch or other support?	☐	☐	
- been struck unconscious?	☐	☐	
- been hospitalized for other than surgery?	☐	☐	
Do you:			
- take minerals, herbs or vitamins?	☐	☐	list on separate page if needed
- think you need minerals, herbs or vitamins?	☐	☐	
- have any drug allergy?	☐	☐	indicate how you were affected

CURRENT MEDICATIONS: (Include dosages, # of pills/capsules/tablets, as well as OTCs (over the counter) medications

1.	2.	3.
4.	5.	6.
7.	8.	9.

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	☐	☐	☐	☐
- spinal examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐
- PAP smear	☐	☐	☐	☐

Continued on next page

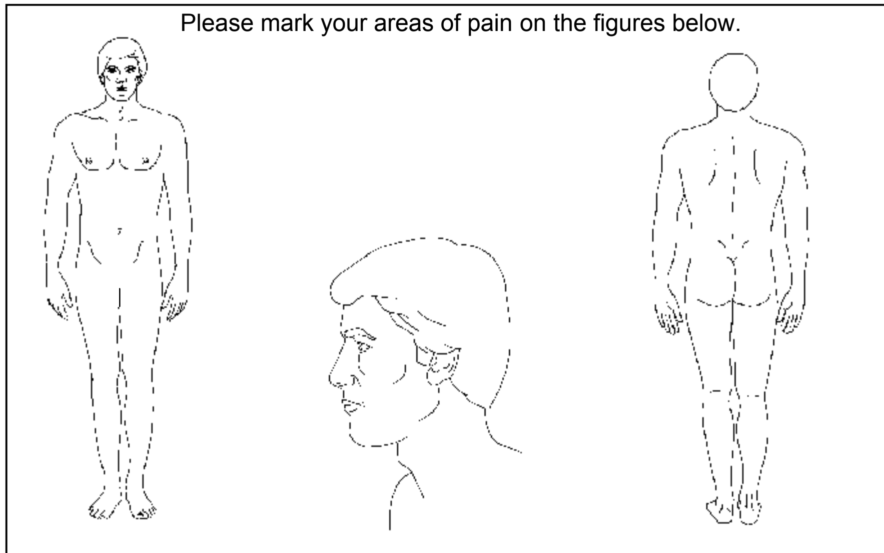
Please list any other health conditions you have been treated for, or surgery you have had in the last ten years. Please include dates if possible.

1. ____________________ 2. ____________________
3. ____________________ 4. ____________________
5. ____________________ 6. ____________________

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture. Examples: Heart disease, Cancer, Diabetes, Liver/Kidney disease, Stroke, Hypertension etc.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.



If there is anything else, not covered in this report of systems, that you think we need to know concerning your condition/problem, please include it here: ____________________

Center for Chiropractic and Pain Rehabilitation ● 3241 NE Broadway Street ● Portland, Oregon 97232 ● (503)282-8582
Dr. Peter G. Macris

SOCIAL HEALTH HISTORY

Vitals:
Present Weight:_________lbs
Height_________ ft _________inches

Occupation:____
Number of hours worked per week:____
Are you satisfied with your job/work?______YES _______ NO
Place of birth:____
Other Places / Countries (that you have lived in):____
Number of hours of sleep per night:________hrs
Do you wake rested? ____________YES _______ NO
Does rest give you any relief from your condition/problem? __YES _______ NO
Do you feel worse as the day progresses?_____YES ______ NO
Is there anything you do that makes your condition/problem better? ___YES _______ NO
Is there anything you do that makes your condition/problem worse? ___YES _______ NO

HABITS	None	Light	Mod	Heavy	
Alcohol	☐	☐	☐	☐	
Coffee/tea	☐	☐	☐	☐	# Cups/day ____________
Tobacco	☐	☐	☐	☐	# Cigarettes/day ________ # Years smoked _______
Drugs	☐	☐	☐	☐	Please note the drugs ______________________________
Exercise	☐	☐	☐	☐	Please state what kind ______________________________
Appetite	☐	☐	☐	☐	
Soft Drinks	☐	☐	☐	☐	
Salty Foods	☐	☐	☐	☐	
Water	☐	☐	☐	☐	# 8oz glasses/day ______________
Sugar	☐	☐	☐	☐	
Artificial Sweeteners	☐	☐	☐	☐	

For the purposes of assessing nutritional status, please complete the following tables

Yesterday's Meals:

Breakfast	Lunch	Dinner

Today's Meals:

Breakfast	Lunch	Dinner

Are there any foods that are particularly bothersome for you to eat? (e.g., gas, belching, reflux, loose stools, digestive cramps, hives, malaise, trouble breathing etc.)

Signature:____ Date:_______________

Center for Chiropractic & Pain Rehabilitation ● **3241 NE Broadway Street● Portland, Oregon 97232**
TEL :(503) 282-8582 **FAX: (503) 460-0814**

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Center for Chiropractic and Pain Rehabilitation LLC, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic (D.C.)

The Doctor of Chiropractic provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a doctor at the Center for Chiropractic and Pain Rehabilitation LLC, I am authorizing them to proceed with any treatment that may be deemed necessary. Furthermore, the procedures, alternatives and risks involved (PARQ), regarding chiropractic treatment, will be fully explained to me prior to any treatment.

Patient Name (printed) ______________________________ Date: ____________

Patient Signature:_______________________________________ Date:____________