# PEAK PERFORMANCE
## C H I R O P R A C T I C

3150 Monsarrat Ave. Suite 202, Honolulu, Hawaii 96815 • Phone (808) 737-5433 • Fax (808) 747-0585

Name ______________

Date ______________ Name ______________

Address ______________

City ______________ State ______ Zip ______ Home Ph. ______________ Cell ______________

Date of Birth ______________ Age ______ Height ______ Weight ______ ☐ Male ☐ Female # of children ______

Employer ______________ Occupation ______________

Work # ______________ E-mail: ______________

Please List activities / sports / hobbies that give you the most pleasure. ______________

______________

______________

How were you referred to our office? ______________

Have you had Chiropractic care before? ______ If yes, when? ______________

If you are experiencing any pain and/or health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. ______________ For how long? ______________
2. ______________ For how long? ______________
3. ______________ For how long? ______________
4. ______________ For how long? ______________

List other doctors consulted for these conditions: 1. ______________ 2. ______________

Name of family physician ______________

Are there any activities, incidents, or events that may have caused these complaints? ______________

If yes please explain: ______________

Do you ever experience any of these complaints while working? ______________

Is this due to an injury or accident? ______ Date of Injury ______________

Have you been involved in an auto accicdent in the last 12 months? ______________

Has this problem been getting better, worse, or staying the same? ______________

What activities or positions make your condition worse? ______________

What activities or positions, if any, make the condition feel better? ______________

Have you ever had any surgeries or hospitalizations? ______ If yes, please list: ______________

Please list any injuries or illnesses that you have had that are not listed above: ______________

______________

Please indicate medications (over the counter) / prescriptions you are currently taking:

☐ Aspirin/Tylenol ☐ Pain Killers ☐ Muscle Relaxers ☐ Insulin ☐ Blood Pressure Meds ☐ Anti Depressents ☐ Heart Meds

☐ Heartburn Meds ☐ Other ______________

______________

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______________

Please draw the location of your pain or discomfort on these images. Use the symbols shown below to represent the type(s) of pain:

D = Dull / Achy

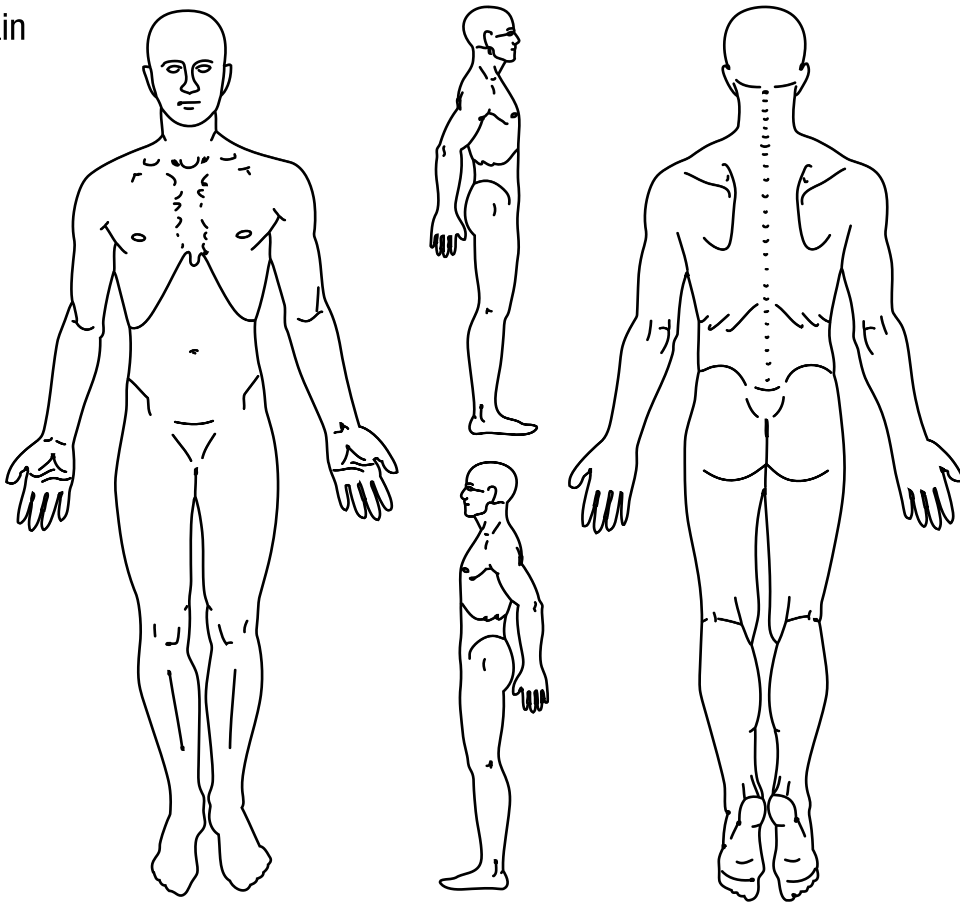
B = Burning

N = Numb

S = Stabbing / Sharp

T = Tingling (Pins & Needles)

C = Cramping / Tight



Below is a list of diseases / symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiopractic care. Please check any of the diseases / symptoms that you have experienced in the last six months.

- ☐ Paralysis
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Excessive Fatigue
- ☐ Excessive Thirst
- ☐ Vomiting
- ☐ High Cholesterol
- ☐ Liver Problems
- ☐ Digestive Problems
- ☐ Frequent Headaches
- ☐ Sudden Weight Loss
- ☐ Bladder Trouble
- ☐ Excessive Urination
- ☐ Discolored Urine
- ☐ Hypo / Hyper Thyroid
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Lung Problems
- ☐ Vision Problems
- ☐ High Blood Pressure
- ☐ Diabetes

Do you:

Smoke ☐ Yes ☐ No How Much: ______________________

Drink Coffee ☐ Yes ☐ No How Much: ______________________

Drink Tea ☐ Yes ☐ No How Much: ______________________

Drink Alcohol ☐ Yes ☐ No How Much: ______________________

**Female Only** Last Period date: ______________________

Birth Control ☐ Yes ☐ No

Are you pregnant ☐ Yes ☐ No

Signature ______________________ Date ____________