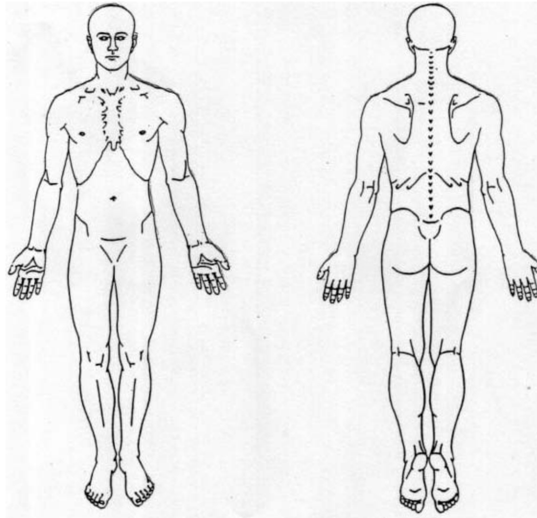
Name___________________
Date: __________

CCC Patient Condition Form

1. Patient Name: ____
2. Approximately when did the condition begin or occur? ___/___/_____ OR just seeking general good health? □ Yes □ No



Please mark area(s) of health concern with X.

3. Describe the conditions, symptoms or purpose of appointment:
   a. ____
   b. ____
   c. ____
   d. ____
4. Describe your pain: □ Burning Pain □ Sharp pain □ Dull Pain □ Ache
5. What caused it? ____
6. What aggravates it? ____
7. What relieves it? ____

Carbondale Chiropractic Center
Family & Sports Chiropractic
267 Brooklyn Street, Suite A
Carbondale, PA 18407
P: 570-282-1240 / F: 570-282-7937

Name___________________
Date: __________

8. Please check any of the following symptoms you are now experiencing:

□ Headache □ Dizziness □ Light Bothers Eyes □ Diarrhea
□ Head seems heavy □ Neck Pain □ Loss of memory □ Clumsiness
□ Cold Feet □ Stiff Neck □ tingling in arms/legs □ Ears Ring
□ Hands Cold □ Sleeping Problems □ tingling in legs/feet □ Face Flushed
□ Nausea □ Back Pain □ Numbness in hands/arms □ Nervousness
□ buzzing in ears □ Constipation □ Numbness legs/feet □ Tension
□ Loss of balance □Cold Sweats □ Burning muscle pain □ Fainting
□ Shortness of Breath □ Fatigue □Irritability □Loss of smell
□ Chest pain/Rib pain □ Pain in arms/legs □ Pain in legs/feet □ Jaw pain
□ Sharp/Shooting pain □ Loss of strength Legs □ Loss of strength – arms □Fever
□ Difficulty swallowing □ other: ____

9. Have you experienced changes to:
□ Eyes (sight) □ Earring (hearing) □ Nose (smell) □ Mouth (taste)
□ Bladder □ Bowels □ Sleep □ Emotion
□ Appetite

Please explain:
____

10. Have you missed work or school as a result of your injuries? □ Yes □ No

11. Do you smoke? □ Yes □ No Number of Packs/Day? ________________

12. Do you drink alcohol? □ Yes □ No Number of drinks? ________________

13. Have you been in our office before? □ Yes □ No

14. List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

Previous accident:	**Date:**
1.	
2.	
3.	

15.

Surgeries/Hospitalizations	Year

16. Allergies?
____

Name___________________
Date: __________

17. List all medications you are now taking and why:

Name	Quantity/day	Reason

18. Do you now or have you ever had:

□ Heart Disease □ Diabetes □ Cancer □ High Blood Pressure
□ Stroke □ Tuberculosis □ Asthma □ Prostate Disorder
□ Thyroid Problem □ Kidney Problems □ Ulcer □ Seizure Disorder
□ Cardiovascular problems/ Stroke □ Scoliosis □ Back Problems
□ Other: ____

19. Allergic/Immunologic:
□ Hives/Eczema □ Hay Fever

20. Cardiovascular:
□ Murmur □ Chest Pain □ Palpitations
□ Dizziness □ Fainting Spells □ Shortness of Breath
□ Difficulty Lying flat □ Swelling Ankles

21. Constitutional:
□ Weight loss □ Fatigue □ Fever

22. Ears, Nose, Throat:
□ Difficulty Hearing □ Buzzing in Ears □ Ringing in Ears □ Vertigo
□ Sinus Trouble □ Nasal Stuffiness □ Frequent Sore Throat

23. Endocrine:
□ Loss of Hair □Heat/Cold Intolerance

24. Eyes:
□ Glasses/Contacts □ Eye Pain □ Light Bothers Eyes □ Double Vision
□ Cataracts

25. Gastrointestinal:
□ Heartburn/Reflux □ Nausea/Vomiting □ Constipation
□ Change in Bowel Movements □ Diarrhea □ Jaundice
□ Abnormal Pain □ Black/Bloody Bowel Movements

26. Genitourinary:
□ Burning/Frequency □ Nighttime □ Blood in Urine
□ Erectile Dysfunction □ Abnormal Discharge □ Bladder Leakage

Carbondale Chiropractic Center
Family & Sports Chiropractic
267 Brooklyn Street, Suite A
Carbondale, PA 18407
P: 570-282-1240 / F: 570-282-7937

Name__________________
Date: __________

27. Hematology/Lymph:
    - □ Easy Bruising □ Gums Bleed Easily □ Enlarged Glands
28. Musculoskeletal:
    - □ Joint Pain / Swelling □ Stiffness □ Muscle Pain
    - □ Neck Pain □ Stiff Neck □ Back Pain
29. Neurological:
    - □ Loss of Strength □ Numbness □ Headaches
    - □ Heavy Head □ Tremors □ Memory Loss
30. Psychiatric:
    - □ Anxiety/Depression □ Mood Swings □ Difficulty Sleeping
    - □ Nervousness □ Tension
31. Respiratory:
    - □ Cough □ Coughing Blood □ Wheezing □ Chills
32. Skin:
    - □ Rash/Sores □ Lesions □ Itching/Burning

WOMEN ONLY:

33. Are you pregnant or is there any possibility you may be pregnant? □ Y □ N □ Uncertain
34. Date of Last Mammogram: ___________ □ Normal □ Abnormal
35. Date of Last PAP: ____________ □ Normal □ Abnormal
36. Onset of Period: ____________
37. Onset of Menopause: ______________
38. Periods Regular? □ Normal □ Abnormal
39. Number of Pregnancies: ___________

Carbondale Chiropractic Center
Family & Sports Chiropractic
267 Brooklyn Street, Suite A
Carbondale, PA 18407
P: 570-282-1240 / F: 570-282-7937