Midtown Chiropractic Clinic ~ Dr. Luke Sakalosky
444 N. Henderson St., Galesburg, IL. 61401 Phone 309-344-4030 Fax 309-344-4032 www.illinoischiropractic.com

Patient Name _____ Date _____

Address_____ City_____ State _____ Zip Code _____

Home Phone _____ Work Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Weight_____ Height_____

Occupation_____ Employer_____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

1. **Reasons for seeking chiropractic care:**

   Primary reason: Secondary reason:
   _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
   _____
   _____

3. **Health History:**

   A. Please indicate if you have a current health issue or a history of any of the following:

		If so, what?
Pulmonary (lung-related) issues?	Yes___ No___	_____
Cardiovascular (heart-related) issues or procedures?	Yes___ No___	_____
Neurological (nerve-related) issues?	Yes___ No___	_____
Endocrine (glandular/hormonal) issues or procedures?	Yes___ No___	_____
Renal (kidney-related) issues or procedures?	Yes___ No___	_____
Gastroenterological (stomach-related) issues?	Yes___ No___	_____
Hematological (blood-related) issues?	Yes___ No___	_____
Dermatological (skin-related) issues?	Yes___ No___	_____
Musculoskeletal (bone/muscle-related) issues?	Yes___ No___	_____
Cancer	Yes___ No___	_____
Stroke/TIA	Yes___ No___	_____

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

B. Previous Injury or Trauma:
_____

Have you ever broken any bones? Which?
_____

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C. Allergies: _____

D. Medications: **Reason for taking:**

_____

_____

(If you have your list of medications we would be pleased to make a copy of them.)

E. Surgeries:
Type of Surgery: _____ Date: _____

_____ Date:_____

_____ Date: _____

Females/ Pregnancies and outcomes:
Pregnancies/Date of Delivery Outcome
_____
_____
_____
_____

4. Family Health History:

Do any family members have a history of
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

5. Social and Occupational History:

A. Job description:
_____

B. Work schedule:
_____

C. Recreational activities:
_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):
_____

Is there anything else in your past medical history that you feel is important to your care here? _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Luke Sakalosky, DC/Midtown Chiropractic Clinic for services performed.

Patient Name _____

Patient or Guardian Signature _____ Date _____

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Patient Name: _____

Chief Complaint

1. Please rate your pain on a scale of 0……10, with 10 being the extreme. _____
2. What type of pain is occurring:
   ❑ sharp ❑ dull ❑ ache ❑ _____
3. When did this symptom first occur? _____
4. How did this symptom happen? _____
5. What makes your symptom worse? _____
6. What relieves the symptom for you? _____
7. How often are your symptoms present:
   ❑ all day ❑ AM ❑ PM
8. Does your symptom disturb:
   ❑ work ❑ sleep ❑ hobbies/recreation
9. Please rate your stress level on a scale of 0……4, with 4 being the extreme. _____

Place an (x) on the picture where your symptoms are present.