E komo mai!
Welcome!

Tell me about you:

Today's date: _____ Last name_____ First name _____Middle Initial_____

What do you prefer to be called? _____. Date of Birth_____. Age _____. Gender: M / F

Street Address _____ City _____ State _____ Zip Code _____

Home Telephone Number_____ Mobile Number_____. Best time to reach you? _____

Email address: _____

Occupation _____ Employer _____

Employer Address _____ City_____ State _____ Zip Code _____

Marital Status: _____. Spouses Name _____

In the event of an emergency, whom should we contact? _____

Relationship _____. Best number where they could be reached _____

Name of your Primary Care Physician _____ Office number _____ Fax number _____

Address: _____ City _____ State _____Zip _____
Do we have permission to release any findings or information related to your care in our office to your family doctor? Yes _____ No _____

Whom may we thank for referring you to our office? _____ Relationship _____.

Reason for your visit…

The reason for today's visit is a result of: Trauma _____. Chronic _____ Sports Injury _____ Work injury_____ Auto Accident _____ Wellness Care _____

When did this condition begin? _____. Please describe the pain and its location: _____

Explain what happened _____

Is this condition getting worse? Yes ____ No ____ Constant _____ Comes and goes _____

Is this condition interfering with: Work _____ School _____ Sleep _____ Daily Routine? Please explain _____

Have you had this or a similar condition in the past? Yes _____ No ____If yes, please explain _____

Has a Medical Physician treated you for this condition? Yes ____ No___ If yes, name and location_____

Please briefly explain the treatment you received _____

Has a Chiropractic Doctor treated you for this condition? Yes ____ No ____ If yes, name and location: _____

Please briefly explain the treatment you received _____

_____

IMUA
4163 Waipua Street, Kilauea, HI 96754/Clinic 808.634-0450
Dr. Denise Walther, Chiropractor

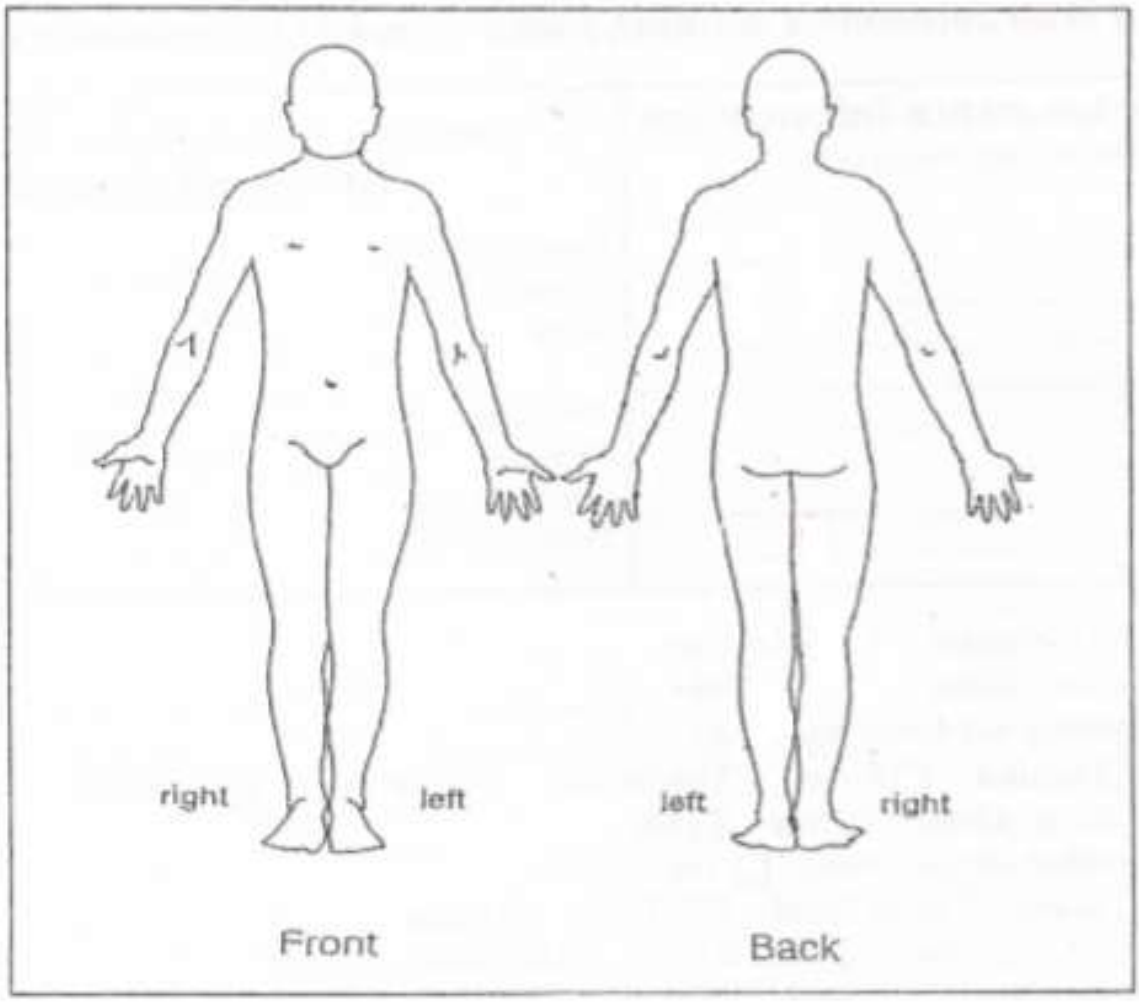
Show me where you are hurting…

Describe your present condition:

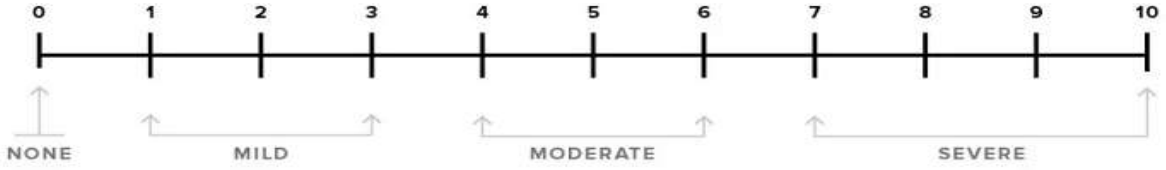
_____

Please mark the body area (s) of injury/pain/discomfort by using the appropriate symbols indicated below.

Numbness	Aching	Stabbing	Burning	Pins and Needles
N	**A**	**S**	**B**	**P**



0-10 NUMERIC PAIN RATING SCALE



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Health History:

Are you taking any of the following medication (s)?

Pain Killers _____ Muscle Relaxers _____ Stimulants _____ Blood Thinners _____ Tranquilizers _____ Insulin _____ Anti-inflammatory _____

Other _____

Do you currently have or have you ever had any of the following diseases/ medical condition (s)? (*Please check to the left to all that applies)*

	Heart Attack/ Stroke		**Diabetes**		**Lower Back Problems**		**Stomach Problems**
	Congenital Heart Defect		**Cancer / Chemotherapy**		**Prosthetic devices/ joints**		**Headaches**
	High / Low Blood Pressure		**Shingles**		**Hepatitis**		**Liver Problems**
	Frequent Neck Pain		**Emphysema**		**Anemia Rheumatic Fever**		**Eye Problems**
	Fainting/ Seizures/ Epilepsy		**Kidney Problems**		**Ulcers/ Colitis**		**Hearing**
	Heart Surgery / Pacemaker		**Alcohol/ Drug Abuse**		**Tuberculosis**		**Scoliosis**
	Mitral Valve Prolapse		**Sinus Problems**		**Arthritis**		**Gallbladder**
	Difficulty Breathing		**HIV+ / AIDS**		**Psychiatric disorders**		**Broken bones**

Please List any other serious medical condition (s) you have or ever had_____

Please list anything that you may be allergic to

_____

Please list previous surgeries with date ___

_____

Please list any past serious accidents with date

_____

Do you smoke? Yes ____ No ____ How long? _____ How much daily?

_____

Are you wearing: Heel Lifts _____ Arch Supports _____ Sole Supports _____ Inner Soles _____?

What do you sleep on? How old is your mattress _____. What kind? _____. Is it comfortable? _____ Do you wake up refreshed?

_____

Do you sleep primarily on your side/ back/ stomach? _____What kind of neck support (pillow) do you use?

_____

How many hours do you sleep? ____ Do you nap during the day and for how long _____

How many hours do you SIT daily? ____ . How many hours are you in front of the computer daily? _____.

Describe your typical daily activities?

_____

Is there anything else you wish to discuss?

Mahalo! I look forward to our time together.

Denise

IMUA
(ee-mooh-ah) Moving forward with Strength, Courage and Strong Spirit