

Dr. John E. Lemon



Family Chiropractic of Saluda
Tele: 804.758.1800

498 Gloucester Rd. Saluda, VA 23149
Fax: 804.758.1803

Family Chiropractic of Gloucester
Tele: 804.824.7303

3438 Geo. Wash. Mem. Hwy. Gloucester, VA 23061
drlemon1@verizon.net

Name: _____

Date: _____

Are your present problems due to an injury? Yes No Enter the date of the injury: _____

Was the injury? Job Related Auto Accident Personal Injury Other: _____

Has the accident been reported? Yes No If so, to whom? To Employer Auto Carrier Other: _____

Briefly describe the accident, injury or illness: _____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

1. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Frequency of Pain Occasional Intermittent Frequent None

Type of Pain Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing None

2. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Frequency of Pain Occasional Intermittent Frequent None

Type of Pain Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing None

3. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Frequency of Pain Occasional Intermittent Frequent None

Type of Pain Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing None

4. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Frequency of Pain Occasional Intermittent Frequent None

Type of Pain Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing None

List any tests, studies or medications received for this condition:

Tests/Studies: _____

Medications: _____

Where you admitted to the hospital due to this condition: Yes No

If yes, what hospital? _____ Transported by? Ambulance Police Other: _____

Date Admitted: _____ Date Released: _____ Length of Stay: _____

List the hospital procedures received: _____

Do you have any current work restrictions due to this condition?

Off work: Yes No Previously From: _____ To: _____

Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

What type of work do you do? _____

Do you suffer from any condition other than that for which you are now consulting us? Yes No _____

HABITS

Current Every Day Smoker

Current Some Day Smoker

Former Smoker

Never Smoker

Drinking Alcohol: (Cups/day): _____

Coffee Cups/Day: _____

Soft Drink Bottles or Cans/Day: _____

Water Cups/Day: _____

EXERCISE

None

Moderate

Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you taking any prescription medication? Yes No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Have you taken any medications in the past? Yes No If yes, which ones?: _____

Do you have allergies to medication? Yes No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____

Allergy: _____ Allergy: _____

Have you ever had any surgeries? Yes No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach
Other _____					

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

GENERAL SYMPTOMS	GASTRO-INTESTINAL	NOSE/THROAT/ EYE/EAR	RESPIRATORY
<input type="checkbox"/> Allergy(What) _____ _____	<input type="checkbox"/> Belching or Gas	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Deafness	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Chills (Constant)	<input type="checkbox"/> Constipation	<input type="checkbox"/> Earache	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Spitting Blood
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Ear Noises	<input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> Fainting	<input type="checkbox"/> Hemorrhoids (piles)	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Frequent Colds	GENITO-URINARY
<input type="checkbox"/> Headache	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Numbness or Pain in arms/legs/hands	<input type="checkbox"/> Heart Burn	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Painful Urination
	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Prostate Trouble
MUSCLES & JOINTS	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Tonsillitis	FOR FEMALES ONLY
<input type="checkbox"/> Backache	CARDIO-VASCULAR	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Cramps
<input type="checkbox"/> Foot Trouble	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Dryness	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Hernia	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Eczema	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Pain Between Shoulders	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hives or Allergy	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Painful Tail Bone	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Itching	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Pregnant Now?
<input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> Rapid Heart	<input type="checkbox"/> Skin Eruptions	
	<input type="checkbox"/> Slow Heart	<input type="checkbox"/> Swollen Joints	
	<input type="checkbox"/> Strokes	<input type="checkbox"/> Swelling Ankles	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles
<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____