

Confidential Patient Information

Today's Date: ____/____/____

Patient Information

First Name: _____ (Preferred Name: _____) MI: ____ Last Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Home Ph.: (____) ____-____ Work Ph.: (____) ____-____ Cell Ph.: (____) ____-____

Birthday: ____/____/____ Sex: Male Female Social Security Number: ____-____-____

E-Mail Address: _____

Marital Status (check one): Single Married Widowed Separated Divorced

Emergency Contact Person Name: _____ Home Ph.: (____) ____-____

Employment \ Student Status

Employment \ Student Status (check one): Employed Full Time Retired Student Not Employed

Employer Information:

Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Occupation \ Job Description: _____

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

Family \ Friends Other Patients Your Primary Care Doctor Insurance Provider Directory Other

Primary Insurance

Insurance Company Name: _____

Policy \ Group Number: _____

ID Number: _____

Insured Information (if other than self):

Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Birthday: ____/____/____

Social Security Number: ____-____-____

Relation to Insured: _____

Insured Employer: _____

Home Phone: (____) ____-____

Work Phone: (____) ____-____

Secondary Insurance

Insurance Company Name: _____

Policy \ Group Number: _____

ID Number: _____

Insured Information (if other than self):

Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Birthday: ____/____/____

Social Security Number: ____-____-____

Relation to Insured: _____

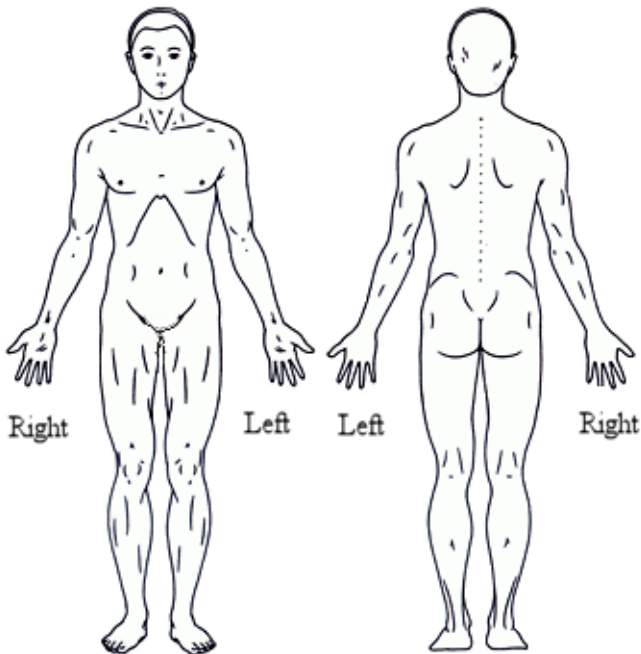
Insured Employer: _____

Home Phone: (____) ____-____

Work Phone: (____) ____-____

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Current Pain



Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =
 Dull Ache OOO
 Burning XXX
 Sharp/Stabbing // /
 Pins, Needles + + +
 Other ^ ^ ^

Please list major complaints in order of most significant to least significant. Please rate your pain for each complaint, 1 = no pain, 10 = most excruciating pain ever.

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10
4. _____ 1 2 3 4 5 6 7 8 9 10
5. _____ 1 2 3 4 5 6 7 8 9 10

Chief Complaint

Purpose of this appointment: _____

Is this complaint: Job Related Auto Accident Sports Injury Chronic Other: _____

When and How did it begin? _____

Has this complaint occurred before? No Yes If Yes, when? _____

What treatments or activities make it better? _____

What treatments or activities make it worse? _____

Does the complaint radiate to other parts of your body? If so, where to? _____

Typically how long does this complaint last? <1 hr <12 hrs >24 hrs

Is the complaint better: Upon waking Morning Midday After Work Evening Bedtime

Is the complaint worse: Upon waking Morning Midday After Work Evening Bedtime

Does this complaint interfere with: Work Home life Activities Sleep Other: _____

Family Doctor Name: _____ May we contact your family doctor if necessary? Yes No

Medications or Supplements taken: _____

Major Surgeries or Hospitalizations due to this complaint: _____

Previous Chiropractic Care: None Doctor's name and last visit: _____

What did you like/dislike about previous chiropractic care? _____

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Current Symptoms		
<p>GENERAL SYMPTOMS</p> <p><input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Headache/Migraines How often? _____ Triggered by? _____</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Wheezing</p> <p>MUSCLES & JOINTS</p> <p><input type="checkbox"/> Low Back Problems</p> <p><input type="checkbox"/> Pain between Shoulders</p> <p><input type="checkbox"/> Neck Problems</p> <p><input type="checkbox"/> Arm Problems</p> <p><input type="checkbox"/> Leg Problems</p> <p><input type="checkbox"/> Swollen Joints</p> <p><input type="checkbox"/> Painful Joints</p> <p><input type="checkbox"/> Stiff Joints</p> <p><input type="checkbox"/> Sore Muscles</p> <p><input type="checkbox"/> Weak Muscles</p> <p><input type="checkbox"/> Walking Problems</p> <p><input type="checkbox"/> Sprains/Strains</p> <p><input type="checkbox"/> Broken Bones</p> <p>CARDIO-VASCULAR</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Pain over Heart</p> <p><input type="checkbox"/> Poor Circulation</p> <p><input type="checkbox"/> Heart Trouble</p> <p><input type="checkbox"/> Rapid Heart</p> <p><input type="checkbox"/> Slow Heart</p> <p><input type="checkbox"/> Strokes</p> <p><input type="checkbox"/> Swelling Ankles</p> <p><input type="checkbox"/> Varicose Veins</p>	<p>EAR/NOSE/THROAT</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear Noises</p> <p><input type="checkbox"/> Enlarged Thyroid</p> <p><input type="checkbox"/> Frequent Colds</p> <p><input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> Nasal Blockage</p> <p><input type="checkbox"/> Nose Bleeds</p> <p><input type="checkbox"/> Pain Behind Eyes</p> <p><input type="checkbox"/> Poor Vision</p> <p><input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> Sore Throats</p> <p><input type="checkbox"/> Tonsillitis</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Chronic Cough</p> <p><input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> Spitting Blood</p> <p><input type="checkbox"/> Spitting Phlegm</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> Kidney Infection</p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> Prostate Problems</p> <p><input type="checkbox"/> Loss of Bladder Control</p> <p>SKIN OR ALLERGIES</p> <p><input type="checkbox"/> Boils</p> <p><input type="checkbox"/> Bruising Easily</p> <p><input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> Eczema/Rash/Dermatitis</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Sensitive Skin</p> <p><input type="checkbox"/> Allergy _____</p>	<p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> Belching/Gas</p> <p><input type="checkbox"/> Colon Problems</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive Hunger</p> <p><input type="checkbox"/> Excessive Thirst</p> <p><input type="checkbox"/> Gall Bladder Trouble</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Liver/Gallbladder</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> Poor Appetite</p> <p><input type="checkbox"/> Poor Digestion</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting Blood</p> <p><input type="checkbox"/> Black Stool</p> <p><input type="checkbox"/> Bloody Stool</p> <p><input type="checkbox"/> Weight Loss/Gain</p> <p>FOR WOMEN ONLY</p> <p><input type="checkbox"/> Birth Control _____</p> <p><input type="checkbox"/> Hormone Replacement</p> <p><input type="checkbox"/> Cramps/Backaches</p> <p><input type="checkbox"/> Excessive/Heavy Flow</p> <p><input type="checkbox"/> Hot Flashes</p> <p><input type="checkbox"/> Irregular Cycle</p> <p><input type="checkbox"/> Miscarriage/Abortion When? _____</p> <p><input type="checkbox"/> Painful Periods</p> <p><input type="checkbox"/> Vaginal Discharge</p> <p><input type="checkbox"/> Breast Pain</p> <p>Pregnant at this Time <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>LMP: _____</p> <p>EDD: _____</p>

Conditions (Past and Present)		
<p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Emphysema</p>	<p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Foot Problems</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Malaria</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pacemaker</p>	<p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Scarlet Fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid Fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> _____</p>

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Date of Last (Approximate)	Have You Ever:	
Physical Examination ___/___/___ Spinal X-Ray ___/___/___ Lab Work ___/___/___	<input type="checkbox"/> Been knocked unconscious? How? _____ <input type="checkbox"/> Had a fractured bone? _____ _____ <input type="checkbox"/> Been treated for a spine or nerve disorder? _____ <input type="checkbox"/> Been in a motor vehicle collision? When? _____ Injuries? _____	<input type="checkbox"/> Used a crutch, or other support? <input type="checkbox"/> Been hospitalized? When and for what condition? _____ _____ <input type="checkbox"/> Ever had surgery? When and for what condition? _____ _____

Medications I Now Take										
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Cholesterol medication</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Blood Pressure medication</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Stimulants</td> <td style="border: none;"><input type="checkbox"/> Blood Thinners</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Tranquilizers</td> <td style="border: none;"><input type="checkbox"/> Pain Killers (including Aspirin)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Muscle Relaxers</td> <td style="border: none;"><input type="checkbox"/> _____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Insulin</td> <td style="border: none;"><input type="checkbox"/> _____</td> </tr> </table> <p style="margin-top: 10px;">For any medications checked above, please supply drug name and dosage:</p> <p>_____</p> <p>_____</p> <p style="margin-top: 10px;">Vitamins and Supplements I now take:</p> <p>_____</p>	<input type="checkbox"/> Cholesterol medication	<input type="checkbox"/> Blood Pressure medication	<input type="checkbox"/> Stimulants	<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Pain Killers (including Aspirin)	<input type="checkbox"/> Muscle Relaxers	<input type="checkbox"/> _____	<input type="checkbox"/> Insulin	<input type="checkbox"/> _____
<input type="checkbox"/> Cholesterol medication	<input type="checkbox"/> Blood Pressure medication									
<input type="checkbox"/> Stimulants	<input type="checkbox"/> Blood Thinners									
<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Pain Killers (including Aspirin)									
<input type="checkbox"/> Muscle Relaxers	<input type="checkbox"/> _____									
<input type="checkbox"/> Insulin	<input type="checkbox"/> _____									

Family History
Is your father living? <input type="checkbox"/> Yes <input type="checkbox"/> No How old (or how old when deceased)? _____ If deceased, what was the cause of death? _____ Is your mother living? <input type="checkbox"/> Yes <input type="checkbox"/> No How old (or how old when deceased)? _____ If deceased, what was the cause of death? _____ If anyone has/had any of the following, write "F" for father, "M" for Mother, "S" for Sister and "B" for brother: Tuberculosis ___ Cancer ___ Mental Illness ___ Diabetes ___ Asthma ___ Heart Disease ___ Stroke ___ Kidney Disease ___ Lung Disease ___ Arthritis ___ Liver Disease ___ Multiple Sclerosis ___ Other _____ Number of children and birthdates: _____

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Social History

Do you drink alcoholic beverages Yes No (if yes, how many per week _____)

Do you use any smokeless tobacco products? Yes No

Do you smoke? Yes No (if yes, how many packs per day? _____)

Do you consume caffeine? Yes No (if yes, how much per day and type? _____)

Do you exercise? Yes No (if yes, describe _____)

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting _____ Sitting _____ Bending _____ Working at computer _____

Why Chiropractic

People go to chiropractors for a variety of reasons and there are different levels of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Stage 1 **Pain relief:** Just get rid of the pain. Relief is short-term.

Stage 2 **Rehabilitation:** Get rid of the pain, but then fix this problem so that it doesn't come back.

Stage 3 **Optimal Health:** Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible.

I guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature

Date

Parent or Guardian Signature (if a minor)