PATIENT INFORMATION

Please provide all information requested below.

Date_____

Last Name_____ First Name_____ MI_____

Address_____

City_____State_____Zip_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

E-mail address:_____

Date of Birth (mm/dd/yyyy):_____ Age:_____ ☐ Male ☐ Female

Social Security #:_____ Driver's License #:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Occupation:_____

Employer:_____

Spouse's Name_____

Spouse's Occupation and Employer:_____

Number of Children:_____ Name & Ages of Children:_____

Who is responsible for this account?_____

Is your condition a result of a: ☐ Auto Accident ☐ Work Related Injury ☐ Home Injury ☐ Fall

Health/Auto Insurance Company & Policy #:_____

Name of Insured:_____

Relationship to Insured:_____ D.O.B. of Insured:_____

Primary Care Physician:_____ Do you need a referral? ☐ Yes ☐ No

In case of emergency please contact:

Name:_____

Address_____

Phone Number(s):_____

Referred to this office by:_____

PAIN DIAGRAM

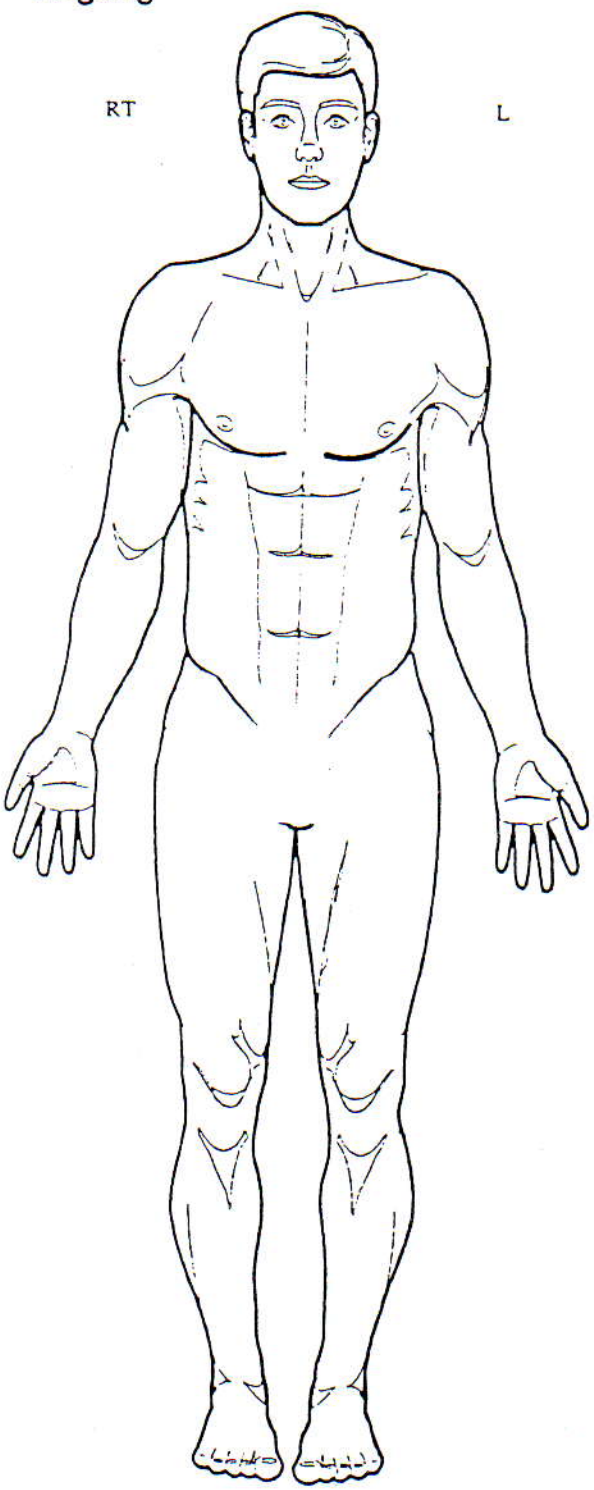
Patient Name:_____ **Date:**_____

Please complete the following Pain Diagram by using the letters at the left to indicate on the diagram your areas of pain:

P = Pain
B = Burning
N = Numbness
S = Stiffness
T = Tingling

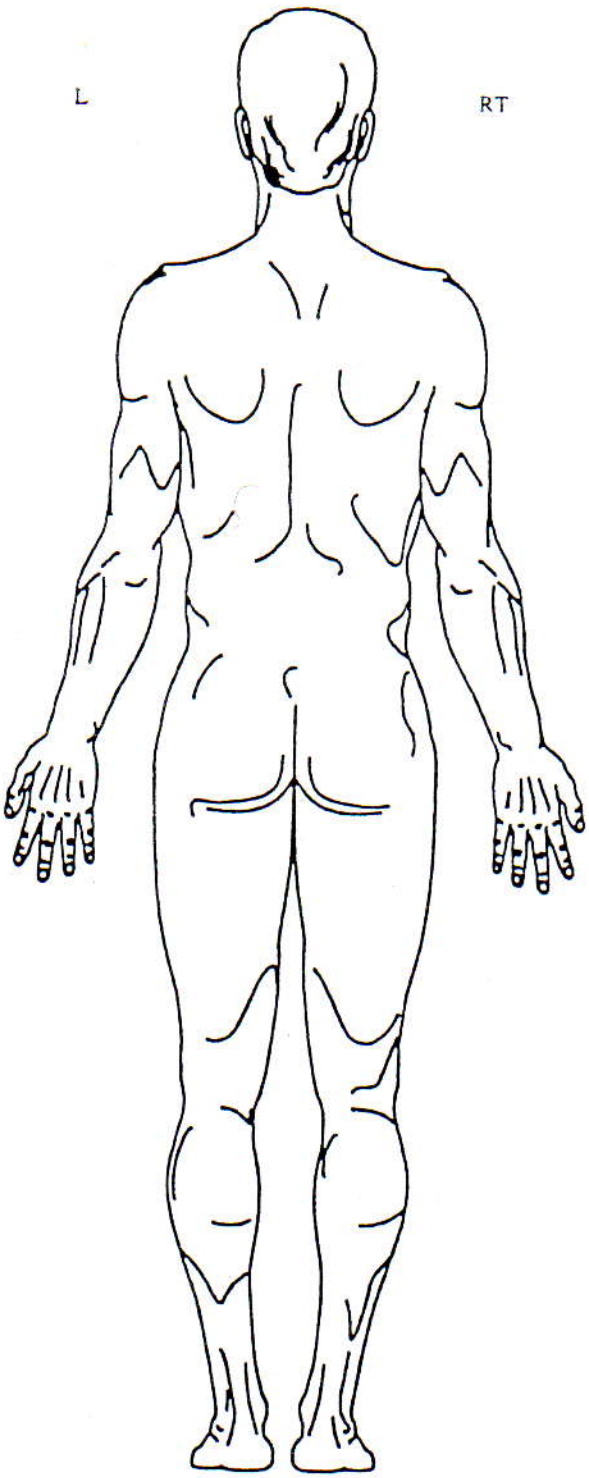
FRONT

RT L



BACK

L RT



SYMPTOM REPORT Side 1

Patient Name:_____ **Date:**_____

PLEASE BE COMPLETE IN ANSWERING THE FOLLOWING ITEMS:

1. **List the SYMPTOM that bothers you the MOST:**

_____.

Character: ☐ Dull ☐ Ache ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Tingling
Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe VAS:_____
Duration: ☐ Constant ☐ Daily ☐ Frequent ☐ Occasional ☐ Episodic

When did this START?_____

What happened to SET THIS OFF?_____

List PREVIOUS EPISODES of this problem:_____

_____.

What makes this problem WORSE?_____

_____.

What makes this problem BETTER?_____

_____.

What TREATMENT have you received for this problem?_____

■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■

2. **List the SYMPTOM that bothers you the 2nd MOST:**

_____.

Character: ☐ Dull ☐ Ache ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Tingling
Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe VAS:_____
Duration: ☐ Constant ☐ Daily ☐ Frequent ☐ Occasional ☐ Episodic

When did this START?_____

What happened to SET THIS OFF?_____

List PREVIOUS EPISODES of this problem:_____

_____.

What makes this problem WORSE?_____

_____.

What makes this problem BETTER?_____

_____.

What TREATMENT have you received for this problem?_____

Please TURN FORM OVER and COMPLETE if you have ADDITIONAL SYMPTOMS ▸▸

Patient Name:_____ **Date:**_____

3. List the SYMPTOM that bothers you the 3rd MOST:

_____.

Character: ☐ Dull ☐ Ache ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Tingling
Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe vas:_____
Duration: ☐ Constant ☐ Daily ☐ Frequent ☐ Occasional ☐ Episodic _____

When did this START?_____

What happened to SET THIS OFF?_____

List PREVIOUS EPISODES of this problem:_____

_____.

What makes this problem WORSE?_____

_____.

What makes this problem BETTER?_____

_____.

What TREATMENT have you received for this problem?_____

4. List the SYMPTOM that bothers you the 4th MOST:

_____.

Character: ☐ Dull ☐ Ache ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Tingling
Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe vas:_____
Duration: ☐ Constant ☐ Daily ☐ Frequent ☐ Occasional ☐ Episodic _____

When did this START?_____

What happened to SET THIS OFF?_____

List PREVIOUS EPISODES of this problem:_____

_____.

What makes this problem WORSE?_____

_____.

What makes this problem BETTER?_____

_____.

What TREATMENT have you received for this problem?_____

If you have ADDITIONAL SYMPTOMS please see the staff for an additional form.

HEALTH HISTORY

Patient Name:_____ **Date:**_____

GENERAL SYMPTOMS: **Check symptoms you currently have or have had in the past:**

GENERAL

- ☐ Allergy
- ☐ Anemia
- ☐ Chills
- ☐ Convulsions
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache/Migraine
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tremors
- ☐ Weight gain

MUSCLE & JOINT

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Hernia
- ☐ Low back pain
- ☐ Neck pain or stiffness

Pain or numbness in:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Painful tail bone
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal curvature
- ☐ Swollen joints

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

RESPIRATORY

- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

GASTRO-INTESTINAL

- ☐ Belching or gas
- ☐ Bloating
- ☐ Bowel changes
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gall bladder trouble
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver disease
- ☐ Nausea
- ☐ Poor appetite
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting of blood

EYES, EARS, NOSE, and THROAT

- ☐ Asthma
- ☐ Blurred vision
- ☐ Colds
- ☐ Dental decay
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Failing vision
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nasal obstruction
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN

- ☐ Bruise easily
- ☐ Change in moles
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions/rash
- ☐ Varicose veins

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Kidney disease
- ☐ Kidney infection/stones
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Prostate problems

MEN ONLY

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Prostate problems
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast implants
- ☐ Breast lump
- ☐ Cramps
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Miscarriage
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Painful menstruation
- ☐ Vaginal discharge

Are you pregnant?

- ☐ Yes, I am pregnant.
- ☐ No, I am not pregnant.

Date of last menstrual period:

_____

CONDITIONS:

Check the conditions you have or have had in the past:

- ☐ AIDS/ARC/HIV+
- ☐ Alcoholism
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High cholesterol
- ☐ Mental/emotional illness
- ☐ Measles
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric care
- ☐ Rheumatoid arthritis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke/TIA
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/growths
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease/STD's
- ☐ Whooping cough
- ☐ _____

Patient Name:_____ **Date:**_____

Have you had chiropractic care before? ☐ Yes ☐ No

If yes, Name of **Chiropractic Doctor** and Last Visit:_____

Your **Primary Care Doctor** (PCP):_____

Other **Doctors/Health Care Providers** you are currently seeing or have seen in the last five years:

_____

Date of last: Physical_____ Blood/Urine Test:_____ Dental Visit_____

PLEASE BE COMPLETE IN ANSWERING THE FOLLOWING ITEMS:

Medications you now take: ☐ Nerve Pills ☐ Pain Pills ☐ Muscle Relaxers ☐ Blood Pressure/Heart Medicine

☐ Cholesterol Medicine ☐ Diabetes ☐ Anti-depressant/Anti-anxiety ☐ Birth Control Pills

Prescription Medicine and **Over-the-Counter Medicine** you now take or have taken in past six months:_____

_____

Vitamins/ Herbal Supplements:_____

List ALL **Surgeries/Operations**:_____

_____

List ALL **Hospitalizations** (other than above):_____

List ALL **Accidents, Injuries, Falls, Sprains**, Etc.:_____

_____

List ALL **Conditions** and **Major Illnesses**:_____

List ALL **Fractures/Broken Bones**:_____

Emotional Stress:	☐ Heavy ☐ Moderate ☐ Light	
Physical Work:	☐ Heavy ☐ Moderate ☐ Light	
Exercise:	☐ Heavy ☐ Moderate ☐ Light	Hours per day:_____ Type:_____
Sleep:	☐ Heavy ☐ Moderate ☐ Light	Hours per day:_____ ☐ Restful Sleep ☐ Not restful
Appetite:	☐ Heavy ☐ Moderate ☐ Light	Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Smoking:	☐ Current ☐ Previous	Packs per day:_____ Number of years_____
Alcohol:	☐ Heavy ☐ Moderate ☐ Light	Times per week:_____
Recreational Drugs:	☐ Heavy ☐ Moderate ☐ Light	Times per week:_____ Type:_____

Do you wear: ☐ Heel Lifts ☐ Arch Supports ☐ Inner Soles ☐ Brace (of any kind)

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No Type:_____

Family History

List any conditions listed in the 'Conditions' section on the first side of this page that another family member has had or currently has:

_____

_____