

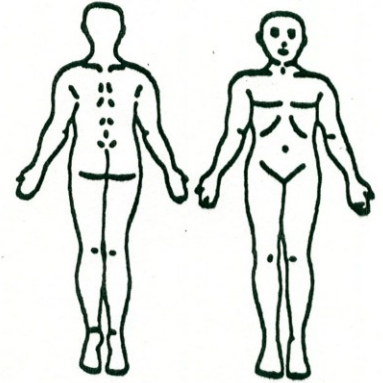
Patient Information

updated 11/2011

Name: _____ First name you prefer: _____ Date: _____
Address: _____ Home Phone: _____ Cell Phone: _____
City/State/Zip: _____ Business/Employer: _____ Bus.Phone: _____
Birth Date: _____ Age: _____ Sex: M F Type of Work: _____
Relationship Status: Married Partnered Single Widowed Divorced Minor Child
Name of Spouse or Significant Other: _____ No. of Children and ages _____
SS#: _____ Referred to this office by: _____
Financial Responsibility: Self Personal Health Ins. Worker's Compensation Auto Ins. Other _____

Symptoms

Reason for visit: _____
When did you first notice the symptoms? _____
What caused it? _____
Where specifically is the problem located? _____
Does it radiate somewhere else, if so, where? _____
Onset was: sudden gradual Is this condition getting progressively worse? yes no
What irritates it? posture work activities time of day
What time of day is the worst? upon waking morning evening after activity other
Which activities are difficult to perform? sitting standing walking changing positions
 lying down bending other _____
Type of pain: sharp dull throbbing numbness aching shooting
 burning tingling cramps stiffness swelling other
Rate the severity of your pain. (1- mild pain or discomfort to 10- severe pain): 1 2 3 4 5 6 7 8 9 10
The pain is constant comes and goes How frequently? _____
What makes it better? positions ice heat stretches medications other _____
Have you lost any time from work due to this condition? yes no
Is there a change in your bodily functions? yes no
 balance bowel habits breathing co-ordination coughing gait grip hearing
 menstrual sexual sleep sneezing urination vision weakness weight
What treatment have you already received for your condition? medication surgery physical therapy other _____
Name of other doctor(s) who have treated you for your condition: _____



Health History

Medication you now take: None Antidepressant Pain killers Muscle relaxers Blood pressure Anti-inflammatory
 Birth control Aspirin/similar Cholesterol Other _____
Vitamins you now take: _____
Major surgery (please include date) appendix _____ tonsils _____ gall bladder _____ hernia _____ heart _____
 hysterectomy _____ back _____ neck _____ knee _____ other: _____
Major accidents or falls: _____
Hospitalization (other than above): _____
Previous chiropractic care (Dr.'s name and approx. date of last visit): _____
Have you been treated for any health condition in the past year? Yes no
If yes, please explain: _____
Members of your health network: MD/DO: _____
Massage Therapist: _____ Therapist/Counselor: _____
Dentist: _____ Gynecologist: _____
Specialists: _____

Check any of the following conditions are applicable:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Colitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinus | _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid Problems | |

Check any of the following you have had in the past:

O=occasional F=frequent)

O F Musculo-Skeletal Code

- Low Back Pain
- Pain Between Shoulder
- Neck Pain

Nervous System Code

- Nervous
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Cold Extremities
- Stress

General Code

- Fatigue
- Allergies
- Loss of Sleep
- Headaches

O F C-V-R

- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion

Gastro-Intestinal Code

- Excessive Thirst
- Diarrhea/Constipation
- Abdominal Cramps
- Gas After Meals
- Bloating After Meals
- Heartburn

O F EENT Code

- Ear Aches

Female Code

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain /Infections
- Breast Pain/Lumps
- Excessive Menstrual Flow
- Hot Flashes
- Vaginal Discharge
- Menopausal Symptoms

Daily Habits

Coffee: Caffeine _____ cups per day

Decaffeinated _____ cups per day

Tea: _____ cups per day

Soft Drinks: sugar: _____ amount per day

Nutrasweet: _____ amount per day

Sugar: heavy moderate light none

Alcohol: _____ # of drinks per day Alcohol of choice _____

Hours per day: _____ sleeping _____ working _____ exercise _____ relaxing

Mattress: firm soft comfortable uncomfortable

Type: standard water futon air

Pipe/cigar: _____ amount per day

Cigarettes: _____ # of packs per day

Fast food: _____ # of meals per week

Number of meals per day: _____

Glasses of water per day: _____ Tap/City Bottled/Filtered

Drugs: heavy moderate light none

Sleep Positions: stomach back right side left side

Number of pillows _____

Recreational sports you have participated in in the last few years: _____

Authorization

I certify that I have read and understand the above questions and have answered them accurately. I agree to be responsible for payment of all services rendered to me. I understand that any health and accident policies I have are an arrangement between the insurance carrier and myself, but that ultimately I am responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of Patient (or parent/guardian if a minor)