PATIENT INFORMATION

General Information

First Name ______________________________
Middle Initial ______________________________
Last Name ______________________________
Called Name ______________________________
Address ______________________________
City ______________________________
State ______________________________
Zip Code ______________________________
Home Phone ______________________________
Cell Phone ______________________________
Email Address ______________________________
Birthdate ______________________________

Sex Male Female
Marital Status Single Married Other ______________
Work Status Employed Full-time student Part-time student
Appt Reminder None Phone Call Text E-mail
Referred By ______________________________

For Office Use Only

Account Number ______________
Diagnosis Codes ______________
Charges ______________________

Insured's Information

Patient is the: Same/Self Spouse Child Other of Insured
Please present your insurance card so we can keep a copy.

Employer Information

Employer Name______________________

Condition Information

Related to Employment Yes No

Related to Auto Accident Yes No
- If yes, name of Auto Insurance Co. ______________
Related to Personal Injury Case Yes No
- If yes, name of lawyer: ______________

Have you ever been to a Chiropractor Yes No
If yes which clinic ______________________________ Did you have X-rays there? Yes No
If yes when was your last appointment? ______________________________
Did you have a good experience? Yes No

Where do you hurt?______________________________When did it start?______________
How did it happen?______________________________
What makes it feel better?______________________________ Worse?______________
Frequency of pain: Constant-100% of time Frequent-75% of time Intermittant-50% of time Occasional-25% of time
What type of pain is it? Achy Sharp Dull Burning Shooting Throbbing Numb Tingling Other:_______

List symptoms individually: Choose the severity level associated with each

______________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
______________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
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List any tests, studies or medications received for this condition:
❑X-ray/MRI: ______________________________
❑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?) ______________________

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	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No See attached photocopy ☐

Medication: ______________________________
Route: Oral
Intravenous
Frequency: ________________
Began Use: ________________

Medication: ______________________________
Route: Oral
Intravenous
Frequency: __________________
Began Use: __________________

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Route: Oral
Intravenous
Frequency: ___________________________
Began Use: ___________________________

Medication: ______________________________
Route: Oral
Intravenous
Frequency: ________________________________
Began Use: ________________________________

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____________________________
Reaction: _______________________________

Medication: _____________________________
Reaction: _______________________________

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 ____

OTHER SYMPTOMS

GENERAL SYMPTOMS

- ❑ Allergy to: ____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux

NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_______ Last Pap Date

_______ Last Mens. Cycl

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

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑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:** ________________