

PATIENT INFORMATION

Name: _____ Date: _____ Address: _____
 Cell Phone: _____ Home Phone (if not cell): _____ E-mail: _____
 SS# (for Medicare patients only): _____ Occupation: _____
 Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____
 How did you hear about us? _____
 Spouse's Name: _____ Spouse's Occupation: _____ How many children do you have? _____
Emergency Contact: _____ Relationship to Patient: _____ Phone: _____
 Primary Care Physician: _____ Have You Been To A Chiropractor Before? ☐ YES ☐ NO Last Visit? _____

INSURANCE INFORMATION (Skip if not utilizing insurance)

Primary Insurance: _____ Insurance ID# _____ Group# _____ Are you the primary policy holder? ☐ YES ☐ NO
 Insured's Name: _____ Insured's DOB: _____ Insured's Phone: _____
 Address: _____ Relationship to patient: _____

PATIENT CONDITION

Chief Complaint: _____
 When did symptoms start? _____
How did symptoms start? _____
 What makes it better? _____
 What makes it worse? _____
 How much of the day do you feel symptoms?
☐ **Constant** ☐ **Frequent** ☐ Occasional ☐ Intermittent
 Are the symptoms getting:
☐ Worse ☐ Better ☐ Staying the Same
 Have you had anything like this before? ☐ YES ☐ NO
 How would you describe your symptoms (check all that apply):
☐ Dull Ache ☐ Tightness ☐ Burning ☐ Sharp
☐ Numb ☐ Tingling ☐ Stabbing ☐ Shooting
☐ Throbbing ☐ Radiating, If Radiates, to where?: _____
 Please rate the intensity of your symptoms from 0-10 with 10 being the worst possible:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
 Please select symptom intensity:
☐ Minimum ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable
 What have you tried that makes the symptoms better? Please indicate:
☐ Medication ☐ Physical Therapy ☐ Surgery
☐ Chiropractic ☐ Massage Therapy ☐ Acupuncture
☐ Other: _____
 What lifestyle activities does this interfere with? (check all that apply)
☐ Prolonged sitting ☐ Walking ☐ Prolonged standing
☐ Lifting ☐ Traveling ☐ Social/Recreational activities
☐ Bending ☐ Sleeping ☐ Personal care (washing, dressing, etc.)
☐ Other: _____

ADDITIONAL COMPLAINT (N/A if you have no 2nd Complaint)

Additional Complaint (if applicable) _____
 When did symptoms start? _____
 How did symptoms start? _____
 What makes it better? _____
 What makes it worse? _____
 How much of the day do you feel symptoms?
☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
 Are the symptoms getting:
☐ Worse ☐ Better ☐ Staying the Same
 Have you had anything like this before? ☐ YES ☐ NO
 How would you describe your symptoms (check all that apply):
☐ Dull Ache ☐ Tightness ☐ Burning ☐ Sharp
☐ Numb ☐ Tingling ☐ Stabbing ☐ Shooting
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☐ Bending ☐ Sleeping ☐ Personal care (washing, dressing, etc.)
☐ Other: _____

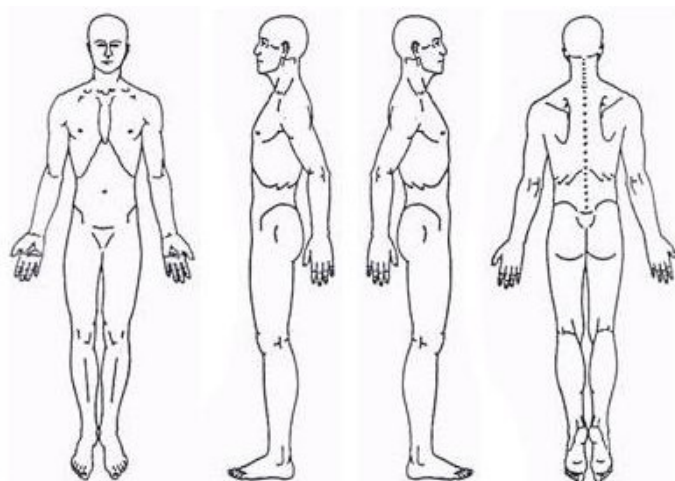


PATIENT PAIN DIAGRAM

Click area(s) of diagram to display painful/symptom location.

Please mark off the areas of your complaint(s) on the diagram. Use the following symbols of the pain diagram to accurately describe your condition.

- P** Pain
N Numbness
T Tingling
B Burning
C Cramping



To be completed in office at the time of your appointment

HEALTH HISTORY

Are you pregnant? ☐ YES ☐ NO

Do you have any implants, pacemakers, etc.? ☐ YES ☐ NO

Allergies: _____

List any surgeries, traumas, and/or hospitalizations (with approx. dates):

MEDICATIONS: Please list any medications you are taking for current symptoms

Are you taking any blood thinners or statins? ☐ YES ☐ NO

(Please bring in a sheet of medications if taking additional meds)

PAST MEDICAL HISTORY

Past/Current Conditions

- | | | | |
|--|--|--|---|
| ☐ Osteoporosis | ☐ Anxiety/ Depression | ☐ Dizziness/Vertigo | ☐ Thyroid/Hormone Disorder |
| ☐ Degenerative Arthritis | ☐ Headaches/Migraines | ☐ Sleeping Trouble | ☐ High Blood Pressure |
| ☐ Rheumatoid Arthritis | ☐ History Stroke/Aneurysm | ☐ Asthma/ Breathing Problem | ☐ Convulsions/Epilepsy |
| ☐ Heart Attack/Heart Disorder | ☐ Cancer | ☐ Digestive Trouble | ☐ Prostate Problems |
| ☐ Sinus Problems | ☐ Diabetes | ☐ Heartburn/Acid Reflux | ☐ Fibromyalgia |
| ☐ Born with bone/Joint disorder | ☐ Autoimmune Disease | ☐ Menstrual Problems | ☐ Neurological Disorder |

OTHER: _____

Family Health History (check any that apply):

- | | | | |
|--------------------------------------|-----------------------------------|--|---------------------------------------|
| ☐ Auto-immune | ☐ Cancer | ☐ Thyroid | ☐ Hypertension |
| ☐ Arthritis | ☐ Diabetes | ☐ Heart disease | ☐ Stroke |

SOCIAL HISTORY AND LIFESTYLE

- | | |
|-----------------------------------|--|
| 1. Smoking (packs/day) _____ | 4. Exercise (days/week) _____ |
| 2. Caffeine(drinks/day) _____ | 5. Sleep (hours/night) _____ |
| 3. Alcohol (drinks/week) _____ | 6. Rate your stress level (0 = No Stress, 10= High Stress) _____ |
| 7. Rate your overall health _____ | |

Patient Signature

Date