PATIENT INFORMATION

Referred by ______________________________

Name____ Sex M F Date_________________________________

Date of Birth__________________________Age___________Social Security #________________________________

Address____State______________Zip________________

Home Phone_____________________Cell Phone______________________Work Phone_______________________

Email ____Marital Status M S D W How Many Children?_____

Occupation _____________________________________Employer____

Name & Number of Emergency Contact_______________________________________Relationship_____________

PAYMENT/INSURANCE INFORMATION

Payment Type: Cash___ Health Insurance___ Medicare___ Personal Injury/Auto___

Primary Insurance________________________________Secondary Insurance________________________________

Insured's Name_______________________________________Birth Date_____________Relationship_____________

Employer____

CHIEF COMPLAINT

Symptoms/Location of Complaint____

Complaint Began when & how?____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging

Begin Gradually or Suddenly? _________________ Has it gotten better or worse?______________________________

Does it radiate or travel(shoot) to any areas of your body? Where? ____

Rate the Severity of pain (0-10) associated with your primary complaint at its worst_________ and its best_____

Rate the Severity of pain (0-10) associated with your secondary complaint at its worst________and its best_____

How frequent is the complaint (circle): Constant Frequent Intermittent Occasional

What makes the symptoms better? ____

What Makes the symptoms worse? ____

Is your complaint the result of an accident ? Yes No Date of Accident___________________________________

Previous interventions for this complaint: Medication Surgery Physical Therapy Acupuncture Chiropractic

Massage____

Did you have an Xray___ MRI____ CT____ Other______________

Have you had the same of similar condition before? If so when?______________________________

Have you been to a Chiropractor before? YES NO If so, when were you last adjusted?________________

Who is your previous Chiropractor?____

Who is your Medical Doctor?____

PAST HEALTH HISTORY

A. Serious Illnesses or Conditions? _______________________________When?________________

B. What Medications are you taking?____

____

C. Past Surgeries?____

D. Previous Injury or Trauma?____

E. Allergies?____

Circle the following conditions you presently have or have had in the past:

ArthitisAsthmaBackaches Cancer Concussion Digestive Issues Dizziness

Epilepsy Fractures Gout Hernia Heart Herniated Disc Migraines

Headaches MS Neuritis Pacemaker Prostrate Sinus Condition Stroke

Thyroid Ulcers Osteoporosis

Other? Specify____

Family History?____

LIFESTYLE

Smoke? YES NO _____packs/day Alcohol _______Drinks/week. Coffee/Caffeine Drinks ____cups/day

Exercise________times/week Sleep _____hours/day on back?______ on side?______ on stomach?_______

Your Stress level can be described as: (circle) Minimal Moderate Severe Intolerable

Work Activity : (circle) Sitting Standing Light Labor Heavy Labor

Are You Pregnant? Yes No Due Date: __________________________