Patient Information

Date:_____

Name_____How did you hear about us?_____

SSN_____ Date of Birth_____ Age_____ Gender: M F

Address_____City_____State_____Zip_____Marital Status_____

Home or Cell Phone_____Email_____# Children_____

Occupation_____Employer_____Work Phone_____

Spouse's Name_____ Parent's Names (if you are under 18)_____

Name of Health Insurance Company_____

ID/Policy #_____ Group #_____ Insured's Name_____

Do you have secondary/supplemental health insurance? □ Yes □ No Company_____

If you have insurance, please present your card(s) to the office manager for processing.

My goal for consulting with the doctor: □ Temporary Relief □ Lasting Correction □Let doctor recommend best type of care

Describe your major complaint:_____

_____

Timing: 0-25% 26-50% 51-75% 76-100%

When did your symptoms begin?_____ **Have you had similar symptoms in the past?** □Yes □No

How did your symptoms begin? □ Work Injury □ Auto Accident □ Other (describe):_____

*If from a personal injury or auto accident, please fill out Personal Injury Questionnaire

Progression (circle): Improving Not-Improving Worsening **What makes it worse?**_____

Describe: Sharp Shooting Achy Burning Numb Tingling **What makes it better?**_____

How severe are the symptoms on a scale of 1-10?(circle) NONE -1 2 3 4 5 6 7 8 9 10-WORST

In general, how would you rate your current overall health? Excellent Very Good Good Fair Poor

Has it affected your ability to work or do housework? □Yes □No How many days off from work/housework?_____

What activity would you like to be able to do again that is difficult or that you cannot do now?_____

What are your favorite hobbies or activities?_____**Currently Affected?** □Yes □No

Have you seen a Chiropractor in the Past? □Yes □No if yes, when was your most recent visit?_____

Why did you see the Chiropractor?_____Doctor's Name?_____

What frequency was prescribed for your care?_____

When was your most recent set of spinal x-rays?_____

Have you had any MRI's or CT scans? Y N If yes, when and where?_____

Who is your Primary Medical Physician?_____Clinic Phone Number _____

HEALTH HISTORY - Please read through the list and check the box next to each condition that applies to you.

Last known: Height_____ **Weight**_____ **Blood Pressure** _____/_____
Do you have an exercise routine? If so, please explain_____
Are you pregnant? ☐Yes ☐No
How is your diet?_____

Musculoskeletal - General

Now	Past	
☐	☐	Degenerative arthritis
☐	☐	Rheumatoid arthritis or Gout
☐	☐	Compression fracture
☐	☐	Osteomyelitis
☐	☐	Osteoporosis

Musculoskeletal Spine

Now	Past	
☐	☐	Poor Posture
☐	☐	Disc injury
☐	☐	Neck problem
☐	☐	Mid-back problem
☐	☐	Low back problem
☐	☐	Scoliosis
☐	☐	Ankylosing spondylitis
☐	☐	Difficulty swallowing because of neck pain
☐	☐	Pain or electric shocks in arms or legs on moving neck

Musculoskeletal Extremity

Now	Past	
☐	☐	Hip or sacroiliac problem L R
☐	☐	Leg, Knee, ankle or foot L R problem
☐	☐	Shoulder problem L R
☐	☐	Arm,elbow,hand problem L R
☐	☐	Rib or chest pain

Nervous System

Now	Past	
☐	☐	Headaches or migraines
☐	☐	Tingling or numbness of arms, legs, hands or feet
☐	☐	Pinched nerve or sciatica
☐	☐	Poor balance
☐	☐	Depression or Anxiety
☐	☐	Difficulty dealing with stress
☐	☐	Dizziness or vertigo
☐	☐	Learning disorder or hyperactivity (ADD/ADHD)
☐	☐	Seizures/Epilepsy
☐	☐	Recent progressive muscle weakness or shaking
☐	☐	Numbness of inner thighs/groin

EENT

Now	Past	
☐	☐	Jaw, TMJ or mouth problem
☐	☐	Visual problems
☐	☐	Ear problems, infections or ringing
☐	☐	Chronic sinus problems
☐	☐	Face pain

GI/GU/Endocrine

Now	Past	
☐	☐	Abdominal pain
☐	☐	Constipation/Diarrhea
☐	☐	Heartburn/Acid Reflux/Ulcers
☐	☐	Uncontrolled Bladder or Bowel
☐	☐	Inflammatory bowel disease
☐	☐	Liver or gallbladder problems
☐	☐	Menstrual problems or PMS
☐	☐	Menopause symptoms
☐	☐	Difficulty getting/staying pregnant/other

Cardio-Pulmonary

Now	Past	
☐	☐	Pacemaker or implanted device
☐	☐	Breathing trouble or Asthma
☐	☐	High blood pressure
☐	☐	History of stroke or aneurysm

Medication-Related Issues

Now	Past	
☐	☐	Medication dependence
☐	☐	Drug or Vaccination reaction
☐	☐	Current drug side-effects
☐	☐	Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
☐	☐	3 or more months of steroid medications or intravenous drugs (past or present)

Injuries and General

Now	Past	
☐	☐	Car crash/whiplash injuries
☐	☐	Work injuries
☐	☐	Ergonomic stress at work
☐	☐	Sports injuries
☐	☐	Smoking habit: How much/day?_____
☐	☐	Drug or alcohol dependence or recovering
☐	☐	Psoriasis or psoriatic arthritis
☐	☐	Unexplained weight loss
☐	☐	Sleeping trouble
☐	☐	Get sick a lot/poor immune function
☐	☐	Fibromyalgia / Chronic fatigue
☐	☐	Tuberculosis, Hepatitis or HIV
☐	☐	Cancer or Tumor
☐	☐	Allergies:_____
☐	☐	Recent fever over 102°F
☐	☐	Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
☐	☐	Constant pain that doesn't improve by changing positions or by lying down
☐	☐	**OTHER HEALTH PROBLEM NOT LISTED:**_____

_____
_____

FAMILY HISTORY:

(circle any that apply)

Back problems - Back/neck surgery - Heart problems – Diabetes - Rheumatoid arthritis - High Blood Pressure - Cancer
Other:_____
_____

LIST ALL SURGERIES AND PROCEDURES YOU HAVE HAD:

_____
_____
_____
_____

LIST ALL MEDICATIONS/VITAMINS/ SUPPLEMENTS/HERBALS:

_____

_____

_____

LIST ANY TRAUMA'S, DATE, AND DESCRIPTION:

_____

_____

_____