MAPLEWOOD • WHITE BEAR
Chiropractic Center

Current Patient Information Form

Name: _____ Date: _____

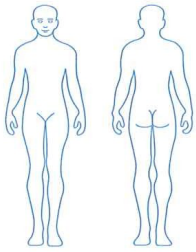
PATIENT CONDITION

Reason for your visit? _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1(least pain) to 10 (most pain) _____



Type of pain
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Buring ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

If you checked any of the above, please explain: _____

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does the pain interfere with any of these? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/day _____
☐ Alcohol — Drinks/week _____
☐ Coffee/Caffeine Drinks — Cups/day _____
☐ High Stress Level — Reason _____

Injuries / Surgeries you have had since your last visit:	Description	Date
Work Injury		
Motor Vehicle Injury		
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS
Name/Dose

ALLERGIES

VITAMINS/HERBS/MINERALS

- Continued Below -

Review of Systems

Please check if you are experiencing any of the following:

Constitutional

- Weight Loss ☐ Yes ☐ No
- Fatigue ☐ Yes ☐ No
- Fever ☐ Yes ☐ No

Eyes

- Glasses/Contacts ☐ Yes ☐ No
- Eye Pain ☐ Yes ☐ No
- Double Vision ☐ Yes ☐ No
- Cataracts ☐ Yes ☐ No

Ear, Nose, Throat

- Diff Hearing ☐ Yes ☐ No
- Ringing in ears ☐ Yes ☐ No
- Vertigo ☐ Yes ☐ No
- Sinus Trouble ☐ Yes ☐ No
- Nasal Stuffiness ☐ Yes ☐ No
- Freq Sore Throat ☐ Yes ☐ No

Cardiovascular

- Murmur ☐ Yes ☐ No
- Chest Pain ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Fainting Spells ☐ Yes ☐ No
- Short of Breath ☐ Yes ☐ No
- Diff laying flat ☐ Yes ☐ No
- Swelling Ankles ☐ Yes ☐ No

Endocrine

- Loss of hair ☐ Yes ☐ No
- Heat/Cold Intolerance ☐ Yes ☐ No

Respiratory

- Cough ☐ Yes ☐ No
- Coughing Blood ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Chills ☐ Yes ☐ No

Gastrointestinal

- Heartburn/reflux ☐ Yes ☐ No
- Nausea/vomiting ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Change in BM ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Jaundice ☐ Yes ☐ No
- Abdominal Pain ☐ Yes ☐ No
- Black/Bloody BM ☐ Yes ☐ No

Genitourinary

- Burning/Freq ☐ Yes ☐ No
- Nighttime ☐ Yes ☐ No
- Blood in Urine ☐ Yes ☐ No
- Erectile Dysfunctn ☐ Yes ☐ No
- Abnormal Discharge ☐ Yes ☐ No
- Bladder Leakage ☐ Yes ☐ No

Allergic/Immunologic

- Hives/Eczema ☐ Yes ☐ No
- Hay Fever ☐ Yes ☐ No

Psychiatric

- Anxiety/ Depression Mood Swings ☐ Yes ☐ No
- Diff Sleeping ☐ Yes ☐ No

Hematology/Lymphy

- Easy Bruising ☐ Yes ☐ No
- Gums bleed easily ☐ Yes ☐ No
- Enlarged Glands ☐ Yes ☐ No

Musculoskeletal

- Joint pain/swelling ☐ Yes ☐ No
- Stiffness ☐ Yes ☐ No
- Muscle Pain ☐ Yes ☐ No
- Back Pain ☐ Yes ☐ No

Neurological

- Loss of Strength ☐ Yes ☐ No
- Numbness ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No
- Tremors ☐ Yes ☐ No
- Memory Loss ☐ Yes ☐ No

Females Only

Date of Last Mammogram _____

☐ Normal ☐ Abnormal

Date of Last PAP _____

☐ Normal ☐ Abnormal

Age onset of periods _____

Age onset of menopause _____

Regular Periods ☐ Yes ☐ No

Number of Pregnancies _____

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