## Today's Date:

## 1. PATIENT INFORMATION

**NAME:** _____
First Middle Last

**Address** _____ # _____

**City/State/Zip** _____

**Cell Phone:** (  ) _____ - _____

**Home Phone:** (  ) _____ - _____

**Sex:** ☐ M ☐ F **Age** _____ **Birthdate** __/__/__

**Social Security #** _____ - _____ - _____

**Driver's License#** _____

**Email Address:** _____

* Your email will not be shared with any 3rd parties, and is used for occasional office announcements & promotions *****

**Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Student

**Number of Children:** _____ **List Ages:** _____

### *Employer Information*

**Occupation:** _____

**Employer:** _____

**Emp. Address:** _____

**City/State/Zip** _____

**Work Phone:** (  ) _____ - _____ **(Ext)** _____

### *Spousal or Parent's/Guardian's Information*

**Name:** _____

**Social Security:** ___ - ___ - ____

**Birthdate:** __/__/____

**Employer:**

## 2. IN CASE OF EMERGENCY

**Name to Contact** _____

**Relationship** _____

**Home Phone** (  ) ___ - ____

**Work Phone** (  ) ___ - ____

**Cell Phone** (  ) ___ - ____

## 3. INSURANCE INFORMATION

**Who is responsible for account?** ☐ Self ☐ Other

**If other, relationship to patient** _____

**Insurance Company** _____

**Group #** _____

**Member I.D. #** _____

**If Insurance is under other name:**

**Subscriber's Name:** _____

**Subscriber's Social Sec.#:** ___ - ___ - ____

**Birth Date of Subscriber** __/__/____

### *Additional Insurance*

**Subscriber's Name:** _____

**Relationship to Patient** _____

**Subscriber's Social Sec.#:** ___ - ___ - ____

**Birth Date of Subscriber** __/__/____

**Insurance Co.**

**Group #** _____

**Member I.D. #** _____

## 4. ACCIDENT INFORMATION

**Is Condition due to accident?** ☐ Yes ☐ No

**If Yes, continue ……..**

**Date of Accident** __/__/____

**Type of accident:** ☐ Auto ☐ Work ☐ Home ☐ Other

**To whom have you reported your accident?**

☐ Auto Ins. ☐ Employer ☐ Ins. Co. ☐ Work Comp.

### *Attorney Information (If applicable)*

**Attorney's Name** _____

**Address** _____

_____

**City/State/Zip** _____

**Phone Number** (  ) ___ -

**5. To whom may we thank for referring you to our office?** _____

*** Please submit your insurance card so that the front staff can make a copy of it. Thank you!**

# 6. PATIENT CONDITION

**1. Reason for Visit:**

- ☐ Headache
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Pain into arms
- ☐ Mid back pain
- ☐ Chest pain
- ☐ Elbow pain
- ☐ Forearm pain
- ☐ Shoulder pain
- ☐ Wrist pain
- ☐ Weak hand grip
- ☐ Cold hands
- ☐ Low back pain
- ☐ Pelvis/Hip pain
- ☐ Pain into legs
- ☐ Knee pain
- ☐ Numbness or tingling into arms/ hands
- ☐ Numbness or tingling into legs/ foot
- ☐ _____

**2. When did your symptoms first occur?**

Onset Date _____/_____/_____

_____ days _____weeks_____months _____ years

**3. How did it occur?**

- ☐ Chronic
- ☐ Gradually
- ☐ Unknown
- ☐ Work
- ☐ Injury
- ☐ Stress

or describe:

**4. Describe your current condition or pain:**

- ☐ Sharp
- ☐ Dull
- ☐ Severe
- ☐ Mild
- ☐ Burning
- ☐ Cold
- ☐ Throbbing
- ☐ Hot
- ☐ Shooting
- ☐ Spasm
- ☐ Gripping
- ☐ Stiff
- ☐ Stabbing
- ☐ Tight
- ☐ Numbness
- ☐ Aching
- ☐ Tingling
- ☐ Cramps

Other_____

**5. How often do you have this pain?**

- ☐ Occasional (25% of the time)
- ☐ Intermittent (50%)
- ☐ Frequent (75%)
- ☐ Constant (100%)

**What makes your condition worse?**

- ☐ Movement
- ☐ Lying down
- ☐ Sitting
- ☐ Bending
- ☐ Walking
- ☐ Lifting
- ☐ Standing
- ☐ Stooping
- ☐ Work
- ☐ Rest
- ☐ Exercise
- ☐ Sleep
- ☐ Other:

**Since it began, is your condition:**

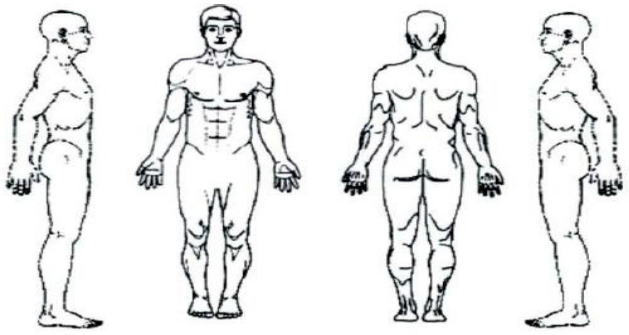
- ☐ Getting Worse
- ☐ No Change/ Same
- ☐ Improving

**6. Rate your pain level (circle a number)** 0 1 2 3 4 5 6 7 8 9 10

**No Pain ……. Slight Pain ……. Moderate Pain ……. Severe Pain**

**7. Please mark X or circle area where you have pain or symptoms**

**A** - Ache
**B** - Burning
**N** - Numbness
**P**- Pins & Needles
**S**-Stabbing
**W**-Weakness



**8. Please list your current:**

Height _____ft. _____ in.

Weight _____ lbs.

**Recently, have you:**

- ☐ Lost weight _____ lbs
- ☐ Gained weight _____ lbs
- ☐ Remained the same

**9. Can you perform daily home activities?**

- ☐ Yes
- ☐ Yes, with some help
- ☐ Very limited
- ☐ Not at all

**Can you perform your work duties?**

- ☐ Yes
- ☐ Yes, with some help or caution.
- ☐ Limited to light duty, restrictions
- ☐ None at all

**Current Stress Levels**

- ☐ None to mild
- ☐ Average/ Normal
- ☐ Moderate
- ☐ Extreme

**10. What past treatment have you had for this condition:**

- ☐ Chiropractic
- ☐ Surgery
- ☐ Bed Rest
- ☐ Injection
- ☐ Medication
- ☐ Other
- ☐ Physical Therapy
- ☐ Analgesics

**Have you had any X-rays, MRI or other diagnostic test(s) for this condition?**

# 7. PATIENT HEALTH QUESTIONNAIRE

**Patient:**

* If you ever had a listed compliant in the past, please check that symptom in the **Past Column.**
* If you are presently troubled by a particular symptom, check that symptom in the **Present Column**
* Knowledge of these conditions may influence the type of treatment/ therapy you receive.

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Rapid heart beat | ☐ | ☐ | Difficulty in Swallowing |
| ☐ | ☐ | Shoulder pain | ☐ | ☐ | Chest Pain | ☐ | ☐ | Emphysema |
| ☐ | ☐ | Upper Arm Pain | ☐ | ☐ | Loss of appetite | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Elbow Pain | ☐ | ☐ | Anorexia | ☐ | ☐ | Rheumatoid arthritis |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Abnormal Weight Gain | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Wrist Pain | ☐ | ☐ | Abnormal Weight Loss | ☐ | ☐ | Constipation |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | Excessive thirst | ☐ | ☐ | Ulcer |
| ☐ | ☐ | Low Back Pain | ☐ | ☐ | Chronic cough | ☐ | ☐ | Liver/ Gall Bladder |
| ☐ | ☐ | Pain in upper leg or hip | ☐ | ☐ | Chronic sinusitis | ☐ | ☐ | Kidney stones |
| ☐ | ☐ | Pain in lower leg or knee | ☐ | ☐ | Heart Burn/ Indigestion | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Pain in ankle or foot | ☐ | ☐ | Depression | ☐ | ☐ | Bladder Infection |
| ☐ | ☐ | Jaw Pain | ☐ | ☐ | Aortic Aneurysm | ☐ | ☐ | Kidney Disorders |
| ☐ | ☐ | Swelling, Stiffness or Joint | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Fainting | ☐ | ☐ | Angina | ☐ | ☐ | Irritable Colon |
| ☐ | ☐ | Visual Disturbances | ☐ | ☐ | Heart Attack | ☐ | ☐ | Colitis |
| ☐ | ☐ | Convulsions | ☐ | ☐ | Stroke | ☐ | ☐ | Irregular Menstrual Flow |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Asthma | ☐ | ☐ | PMS |
| ☐ | ☐ | Headaches | ☐ | ☐ | Tumor | ☐ | ☐ | Breast Soreness or Lumps |
| ☐ | ☐ | Muscular incoordination | ☐ | ☐ | Cancer | ☐ | ☐ | Endometriosis |
| ☐ | ☐ | Tinnitus (ringing in ears) | ☐ | ☐ | Blood Disorder | ☐ | ☐ | HIV / AIDS |
| ☐ | ☐ | General Fatigue | ☐ | ☐ | Dermatitis/ Rash | ☐ | ☐ | Prostate problems |
| ☐ | ☐ | Anemia | ☐ | ☐ | Diabetes | ☐ | ☐ | Abnormal Urination |

**If a Family member has had any of the following, please mark the appropriate box:**

| | | | | |
|---|---|---|---|---|
| ☐ Cancer | ☐ Rheumatoid Arthritis | ☐ Diabetes | ☐ Heart Problems | ☐ Chronic Headaches |
| ☐ Strokes | ☐ High Blood Pressure | ☐ Lupus | ☐ Lung Problems | ☐ Chronic Back Pain |

| EXERCISE | WORK ACTIVITY | HABITS | MEDICATIONS |
|---|---|---|---|
| ☐ None | ☐ Sitting | ☐ Smoking | _____ |
| ☐ Light | ☐ Standing | ☐ Alcohol | _____ |
| ☐ Daily | ☐ Light Labor | ☐ Coffee/ Caffeine | _____ |
| ☐ Moderate | ☐ Heavy Labor | ☐ High Stress Level | Allergies: _____ |
| ☐ Heavy | ☐ Repetitive Arm Movements | ☐ Hours Sleep _____ | _____ |

| PAST INJURIES/ SURGERIES | Date | Description |
|---|---|---|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Auto Accidents/ Injuries | _____ | _____ |
| Work Related Injuries | _____ | _____ |
| Surgeries | _____ | _____ |
| Hospitalizations | | |

**Female Only** **Are you pregnant and/or possibly pregnant?** Yes ☐ No ☐ **Due Date:** ___/_____/____

I certify that aforementioned information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately Whenever I have changes in my health condition or health plan coverage(s) in the future.

**Patient's Signature or Parent if Minor: x** **Date:**