ABOUT YOU

First Name ______________________ **Middle Name** ______________________

Last Name ______________________

Street Address ____

Address Line 2 ____

City ___________________________ **State** ____________ **Zip** _________________

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email Address_______________________________

Date of Birth ____ / ____ / ________ **Gender** ☐ Male ☐ Female

Height _______'_______" **Weight** _______ **lbs**

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _______________ **Spouse's Name** _______________________

EMERGENCY CONTACT INFORMATION

Name _______________________________

Phone ____-____-_____ **Relation to You** ______________________

REFERRAL INFORMATION

Referring Physician ______________________ **Contact Info** ______________________

Referring Patient ______________________

Are You Working with an Attorney? ☐ Yes ☐ No

How Did You Hear About Us?

☐ Word of Mouth ☐ Advertisement ☐ Social Media ☐ Direct Marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / ________

How long have you had this complaint?
- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

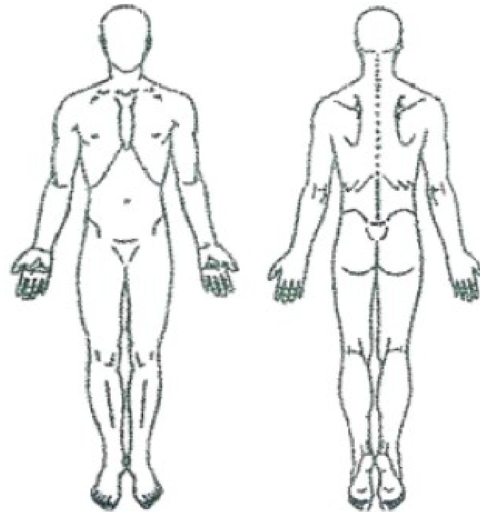
What caused this condition? ______________________________

What is the date this condition began? (Skip if due to accident) ____ / ____ / ________

What terms describe your discomfort best? (aching, burning, tingling, etc.) ______________________________

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None										***Unbearable***
0	1	2	3	4	5	6	7	8	9	10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) ______________________________
____

What treatment have you received for this condition up to now? ______________________________
____

What aggravates this condition? ____________________

What improves this condition or gives you relief? ____________________

Have other health care provider(s) performed tests related to this condition? ____________________

Have you ever had any previous episodes of this condition? ____________________

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones, or Joints	☐ No ☐ Yes	**Explain:** ________
Nerves, Headaches, Dizziness, or Emotional	☐ No ☐ Yes	**Explain:** ________
Head, Eyes, Ears, Nose or Throat	☐ No ☐ Yes	**Explain:** ________
Heart, Blood Pressure, or Circulation	☐ No ☐ Yes	**Explain:** ________
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No ☐ Yes	**Explain:** ________
Stomach, Bowels or Digestive Conditions	☐ No ☐ Yes	**Explain:** ________
Genital, Bladder, or Urinary Conditions	☐ No ☐ Yes	**Explain:** ________
Diabetes, Thyroid or Glandular Conditions	☐ No ☐ Yes	**Explain:** ________
Skin or Bleeding Conditions	☐ No ☐ Yes	**Explain:** ________
Allergies or Sensitivities	☐ No ☐ Yes	**Explain:** ________

PERSONAL AND FAMILY HISTORY

Question	Answer	
Have you had any surgical procedures?	☐ No ☐ Yes	**Explain:** ____________________
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes	**Explain:** ____________________
Do you have a past history of accidents or trauma?	☐ No ☐ Yes	**Explain:** ____________________
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes	**Explain:** ____________________
Are you presently taking any medication?	☐ No ☐ Yes	**Explain:** ____________________
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?	☐ No ☐ Yes	**Explain:** ____________________

WORK AND SOCIAL HABITS

Current work habits: select all that apply

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits: select all that apply

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits: select all that apply

- ☐ No current exercises
- ☐ Exercise daily
- ☐ Exercise 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits: select all that apply

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

ADULT MEN'S HEALTH

Do you have pain or a lump in your scrotum or testicles?	☐ Yes ☐ No
Do you have an impaired libido (sex drive)?	☐ Yes ☐ No
Do you have discharge from your penis?	☐ Yes ☐ No
Do you have prostate issues?	☐ Yes ☐ No
When was your last prostate exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a prostate exam ☐ Prefers not to answer or don't know
When was your most recent PSA (Prostate-Specific Antigen) blood test?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PSA blood test ☐ Prefers not to answer or don't know
What was your PSA (Prostate-Specific Antigen) level on your latest test?	☐ Normal or low ☐ Moderate ☐ High ☐ Never had a PSA level done ☐ Prefers not to answer or don't know

ADULT WOMEN'S HEALTH

Question	Answer
Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Do you experience painful periods?	☐ Yes ☐ No
Do you have irregular cycles?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Do you perform a regular self-breast examination?	☐ Yes ☐ No
Do you take Hormone Replacement Therapy?	☐ Yes ☐ No
Do you take oral contraceptives?	☐ Yes ☐ No
When was your last PAP/pelvic exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP or pelvic exam ☐ Prefers not to answer or don't know
When was your last mammogram?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram exam ☐ Prefers not to answer or don't know
What was the date of your last menstrual period? (only answer if still menstruating)	☐ Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ Postmenopausal ☐ Have not yet begun menstruation ☐ Prefers not to answer or don't know

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: ____________________________________ **Date:** _____ / _____ / _________