



TODAY'S DATE: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle Initial) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Work Number: _____ Cell number: _____

E-mail Address: _____ May we leave messages at the above numbers Yes No

Birth Date: _____ Sex: Male Female Social Security number: _____

Relationship to Policyholder: Same Spouse Child Other _____

Patient Status: Married Single Separated Divorced Widowed Other _____

Employment Status: Full Time Part Time Retired Not Employed Student

Occupation: _____ Employer's Name: _____ Phone Number: _____

Referred to Office by: Doctor Friend Walk/Drive-by Yellow Pages Newspaper Insurance List Internet
 Other _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Address: _____

Policy Claim Number: _____ Group #: _____

Check box if the following information has been completed above: Information Completed

Policyholder's Name: (Last) _____ (First) _____ (Initial) _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ Sex: Male Female Social Security number: _____

Secondary Insurance: _____ Phone: _____

Address: _____

Policy Claim Number: _____ Group #: _____

Check box if the following information has been completed above: Information Completed

Policyholder's Name: (Last) _____ (First) _____ (Initial) _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ Sex: Male Female Social Security number: _____

Name: _____

Date: _____

CURRENT SYMPTOMS/COMPLAINTS

Have you ever seen a chiropractor before? yes no If yes, when and why? _____

Reason for today's visit? _____

Have you had a similar condition in the past? yes no

If you have been injured, are your complaints related to a(n):

- Auto Accident
 Work Injury
 Sports Injury
 Other (please describe): _____
- } Please provide date of injury: _____

When did the current symptom(s)/pain begin? _____

If you are in pain, is it: improving remaining the same worsening

How often is there pain: constant (76-100%) frequent (51-75%) occasional (26-50%) intermittent (0-25%)

Does the pain interfere with: work sleep recreation daily routine mood and irritability

Have you been treated by anyone else for this condition? yes no If yes, what treatment have you received and who administered this treatment? Type of care received _____

Name of facility/doctor: _____

Results of care: positive no change other If other, please explain: _____

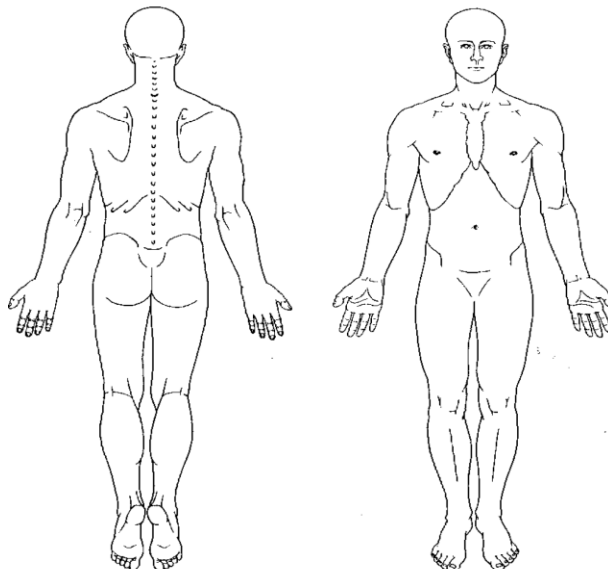
Which of the following activities are difficult to perform due to the pain? (mark all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Laying on back | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Pushing/pulling | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Laying on stomach | <input type="checkbox"/> Bending backward | <input type="checkbox"/> Twisting | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Laying on side | <input type="checkbox"/> Standing for long periods of time | <input type="checkbox"/> Reaching | <input type="checkbox"/> Getting in/out of car |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Getting in/out of seated position | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Sneezing/Coughing |
| <input type="checkbox"/> Getting Dressed | <input type="checkbox"/> Working at a computer/desk | <input type="checkbox"/> Gripping | <input type="checkbox"/> Other: _____ |

PAIN RATING

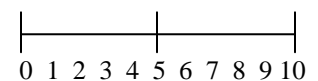
Please indicate on the drawing the location of your pain or discomfort. Use the symbols shown below to represent the type(s) of pain:

- D**=Dull Ache
- B**=Burning
- N**=Numbness
- S**=Stabbing/Sharp
- T**=Tingling
- X**=Stiffness/Tightness
- O**=Spasm

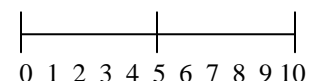


Please rate the severity of your chief complaint pain (10 = worst pain):

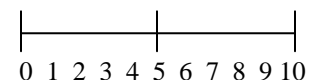
At its **worst**:



At its **best**:



Currently:





Name: _____

Date: _____

PAST HEALTH HISTORY

Please check the box located next to the condition or symptom listed below in which you now have or have had previously. It is important to know your health history so that we can provide the highest quality of care for you. This report is confidential.

GENERAL HEALTH

- Allergies
- Seizure
- Dizziness or fainting
- Headache
- Numbness

MUSCLE & JOINT

- Arthritis
- Bursitis
- Sciatica
- Low back pain
- Neck pain or stiffness
- Middle back pain
- Swollen joints
- Shoulder pain
- Arm pain
- Elbow pain
- Wrist pain
- Leg pain
- Hip pain
- Knee pain
- Foot pain

GASTRO-INTESTINAL

- Acid-reflux
- Colon trouble
- Irritable Bowel Syndrome (IBS)
- Difficult digestion
- Gall bladder trouble
- Liver trouble
- Stomach pain

EYES, EARS, NOSE, & THROAT

- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Ear noise
- Ear pain
- Nasal obstruction
- Nose bleeds
- Sinus infection or trouble

CARDIO-VASCULAR

- Heart attacks
- Heart disease
- High blood pressure
- Low blood pressure
- Pain over heart
- Rapid heart beat
- Slow heart beat
- Swelling of Ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting up blood
- Spitting up mucous
- Wheezing

GENITO-URINARY

- Bed-wetting
- Blood in urine
- Blood urine
- Frequent urination
- Bladder control
- Bladder infections
- Prostate trouble
- Painful urination

SKIN

- Bruise easily
- Dryness
- Rashes
- Varicose veins

If you feel an explanation is needed, you may use this space. _____

FAMILY HEALTH HISTORY

CHECK THE BOXES OF THE FOLLOWING CONDITIONS YOU HAVE OR HAD AND **CIRCLE** THE CONDITIONS THAT MAY RUN IN YOUR FAMILY.

- | | | | | |
|---|-------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> ARTERIOSCLEROSIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIABETES | <input type="checkbox"/> ECZEMA | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> GOITER | <input type="checkbox"/> GOUT | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> MALARIA | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> MUMPS | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> POLIO | <input type="checkbox"/> STROKE | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> ULCERS | |

MEDICATIONS / SUPPLEMENTS

Please list any current dietary supplements, prescription and/or over-the-counter medications and reason for use:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

