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PATIENT INFORMATION

Date: _____

Name: _____ SS#: _____ Age: _____
Address: _____ City: _____ State: _ Zip: _____
Birthdate: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail Address: _____ Sex: Male Female
Marital Status: Single Married Separated Widowed Divorced # of Children: _____
Employer: _____ Referred by: _____
Employer Address: _____ Job Title: _____
Spouse's Name: _____ Spouse's Employer: _____
By what name may we call you? _____

Medical Information:

Present Complaint: _____

_____

When did condition begin? _____ How did it develop? _____
What makes it feel better? _____ Worse? _____
Have you ever been involved in an Auto Accident? Never Within two years Over 2 years ago
Other Doctors that have treated this condition: _____

_____

Previous Medical Problems/Surgeries: _____

_____

_____

Previous Chiropractic Care: Yes No Name: _____

PLEASE RATE YOUR PAIN/STIFFNESS BELOW (CIRCLE SEVERITY).

1 = Minimal and 10 = Severe

Neck Pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10
Mid Back Pain (between shoulder blades): 0 1 2 3 4 5 6 7 8 9 10
Lower Back Pain: 0 1 2 3 4 5 6 7 8 9 10
Leg and/or Buttock Pain: 0 1 2 3 4 5 6 7 8 9 10
Other: _____ 0 1 2 3 4 5 6 7 8 9 10
Other: _____ 0 1 2 3 4 5 6 7 8 9 10

Use these symbols below to mark the location of your symptoms:

ACHE....AAAAA
SHARP PAIN..../////
NUMBNESS....=====
PINS & NEEDLES.....00000

Doctor's Use: _____

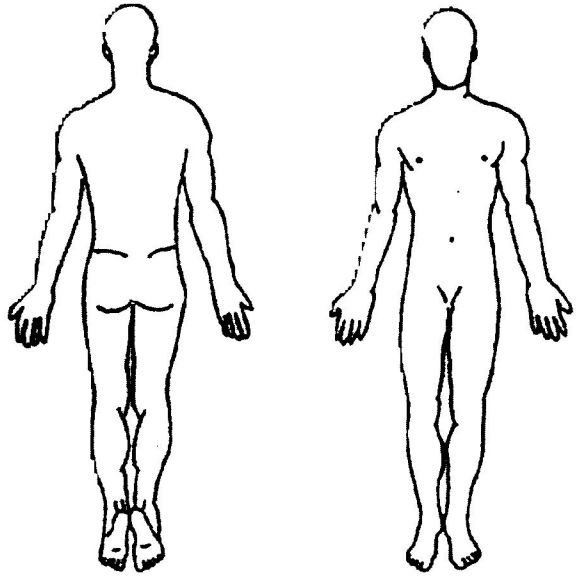
_____

_____

_____

_____

_____



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Check any of the following conditions you have EVER had in the past:

__ Pneumonia __ Mumps __ Influenza __ Anemia
__ Rheumatic Fever __ Pleurisy __ Heart Disease __ Polio
__ Chicken Pox __ Arthritis __ Lowback pain __ Tuberculosis
__ Diabetes __ Epilepsy __ Measles __ Whooping cough
__ Mental Disorder __ Cancer __ Thyroid

Check any of the following conditions you CURRENTLY have or have had in the last 6 months:

__ Low Back Pain
__ Pain Between Shoulders
__ Neck Pain
__ Arm Pain
__ Joint Pain/Stiffness
__ Walking Problems
__ Problems Chewing
__ General Stiffness
__ Nervousness
__ Numbness
__ Paralysis
__ Dizziness
__ Forgetfulness
__ Confusion/Depression
__ Fainting
__ Convulsions
__ Cold/Tingling Extremities
__ Stress
__ Menstrual Irregularity
__ Menstrual Cramping
__ Vaginal Pain/Infections
__ Poor/Excessive Appetite
__ Excessive Thirst
__ Frequent Nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Liver Problems
__ Gall Bladder Problems
__ Weight Trouble
__ Abdominal Cramps
__ Gas/Bloating after Meals
__ Heartburn
__ Black/Bloody Stool
__ Colitis
__ Bladder Trouble
__ Painful/Excessive Urination
__ Discolored Urine
__ Prostate/Sexual Dysfunction
__ Breast Pain/Lumps
__ Fatigue
__ Allergies
__ Loss of Sleep
__ Fever
__ Headaches
__ Short Breath
__ Blood Pressure Problems
__ Irregular Heartbeat
__ Heart Problems
__ Vision Problems
__ Lung Problems
__ Varicose Veins
__ Ankle Swelling
__ Stroke
__ Chest Pain
__ Dental Problems
__ Sore Throat
__ Ear Aches
__ Hearing difficulty
__ Stuffed nose

Females: Are you currently Pregnant? Y or N **Start-date of last period:**_____

Are you presently taking: __ Pain pills __ Muscle relaxers __ Insulin __ Tranquilizers __ Aspirin __ Birth Control Pills __ Vitamins Other _____

Who is your Medical Doctor? _____

Do you sleep on your: __ Back __ Side __ Stomach **Type of Pillow:** __ Orthopedic __ Feather __ Foam __ Fiberfill

Type of Bedding you currently use: __ Firm Mattress __ Soft Mattress __ Waterbed **Age of Bedding:** ____ Years

Circle if you CURRENTLY INTAKE any of the following substances:

Coffee: None Light Moderate Heavy
Tea: None Light Moderate Heavy
Alcohol: None Light Moderate Heavy
Cigarettes: None Light Moderate Heavy
White Sugar: None Light Moderate Heavy
White Flour: None Light Moderate Heavy

Circle below your HABITS in the following activities:

Exercise: None Light Moderate Heavy
Appetite: None Light Moderate Heavy
Sleep: # of hours sleep per night: _____
Quality of Sleep: Good Fair Poor
Any additional comments: _____
_____

In case of an Emergency, please notify:

Name: _____
Relationship: _____
Address: _____
_____
Phone:_____ Home
_____ Work
_____ Cell

Doctor's Use: _____
_____
_____
_____

X _____ / _____
(Signature of Patient / Guardian) **(Date)**