WELCOME

Patient #_____

Patient Information

Thank you for choosing our office for your chiropractic needs. Please fill out the information below.
If you have any questions, please feel free to ask. (Please Print)

Name _____ Date_____
Last Middle Initial First

Address_____
Street City State Zip

Sex ☐ Female ☐ Male Age_____ Birthdate_____ E-mail_____
Mo/Day/Year

Home Phone ( )_____ Cell Phone ( )_____ Work ( )_____

Social Security # _____ Driver's License # _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation_____ Patient Employer_____

Employer Address & Phone_____

Spouse Occupation_____ Spouse Employer_____

(If Student or Minor)
Parent's Name, Address & Phone_____

Person to contact in case of emergency_____

Whom may we thank for referring you?_____

Insurance Information

Insurance Company_____

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Name of Employer_____ Work Phone_____

Symptoms

Please describe your problem and how it began. Date problem began____/____/_____

_____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?	☐ Intermittently	☐ Occasionally	☐ Frequently	
Describe your current pain/symptoms:	☐ Sharp/stabbing	☐ Throbbing	☐ Aches	
	☐ Dull	☐ Soreness	☐ Weakness	
	☐ Numbness	☐ Shooting	☐ Gripping	
	☐ Burning	☐ Tingling	☐ Other_____	
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change	
What makes the problem better?	☐ Nothing	☐ Lying Down	☐ Walking	☐ Standing
	☐ Sitting	☐ Movement	☐ Exercise	☐ Inactivity/Rest
Can you perform your daily activities?	☐ Yes	☐ Yes, with help	☐ Not at all	
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all	
Describe your job requirements:	☐ Mainly sitting	☐ Light labor	☐ Heavy labor	
Can you perform your work activities?	☐ Yes, all of them	☐ Only some	☐ None at all	
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High	

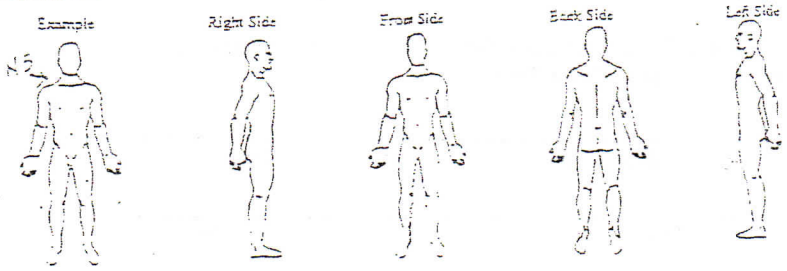
CONTINUED ON BACK

What treatment(s) have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)_____

Have you had x-rays, MRI or other tests for this condition? _____ Which tests and when?_____

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using scale of 1 (discomfort) to 10 (extreme pain).

Numbness.....N
Burning.....B
Pins & Needles...P
Aching.....A
Stabbing.....S



Medical History

Present weight:_____pounds Height:_____feet _____inches
Current medications:_____

If you have ever had a listed symptom in the past, please check the "past" box. If you presently have a symptom, please check the "present box".
Knowledge of these conditions may influence the type of treatment/therapy you receive.

Past	Present	Condition
☐	☐	Neck pain
☐	☐	Hand pain (R___L___)
☐	☐	Wrist pain(R___L___)
☐	☐	Upper back pain
☐	☐	Lower back pain
☐	☐	Pain in upper leg(R___L___)
☐	☐	Pain in lower leg(R___L___)
☐	☐	Pain in ankle or foot(R___L___)
☐	☐	Headaches
☐	☐	Visual disturbances
☐	☐	Frequent urination
☐	☐	Kidney stones
☐	☐	Constipation/irregular bowel
☐	☐	Hepatitis
☐	☐	Chest pains
☐	☐	Stroke (date_____)
☐	☐	Anorexia/Bulimia
☐	☐	HIV/AIDS
☐	☐	Fainting
☐	☐	Tobacco, frequency_____
☐	☐	Breast Soreness Lumps
☐	☐	Birth control, type_____
☐	☐	Coffee/tea/caffeinated soft drinks: cups/cans per day_____

Past	Present	Condition
☐	☐	Muscular incoordinations
☐	☐	Arthritis
☐	☐	Heartburn/indigestion
☐	☐	General fatigue
☐	☐	Dermatitis/eczema/rash
☐	☐	Chronic cough
☐	☐	Chronic sinusitis
☐	☐	Excesssive thirst
☐	☐	Jaw pain
☐	☐	Dizziness
☐	☐	Painful urination
☐	☐	Kidney disorders
☐	☐	Irritable bowel
☐	☐	Heart attack date_____
☐	☐	High blood pressure
☐	☐	Loss of appetite
☐	☐	Blood disorder
☐	☐	Epilepsy
☐	☐	Convulsions
☐	☐	Alcohol, frequency_____
☐	☐	Irregular menstrual flow
		PMS

Past	Present	Condition
☐	☐	Swelling, stiffness of joint(s)
☐	☐	Rheumatoid arthritis
☐	☐	Angina
☐	☐	Depression
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Difficulty in swallowing
☐	☐	Diabetes
☐	☐	Tinnitus (ear noises)
☐	☐	Bladder infection
☐	☐	Prostate problems
☐	☐	Loss of bladder control
☐	☐	Colitis
☐	☐	Aortic aneurysm
☐	☐	Rapid heart beat
☐	☐	Abnormal weight Gain Loss
☐	☐	Tumor, explain_____
☐	☐	Cancer, explain_____
☐	☐	Drug or alcohol abuse
☐	☐	Endometriosis
☐	☐	Profuse menstrual flow

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

☐ Cancer	Family member_____
☐ Chronic back problems	Family member_____
☐ Chronic headaches	Family member_____
☐ Diabetes	Family member_____
☐ Heart problems	Family member_____
☐ High blood pressure	Family member_____
☐ Lung problems	Family member_____
☐ Lupus	Family member_____
☐ Rheumatoid arthritis	Family member_____
☐ Osteoporosis	Family member_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Signature Date