CONFIDENTIAL PATIENT INFORMATION

Date: _____

Patient Name:_____
Last First/Legal Middle Initial Preferred Name

Address:_____
Street City State Zip

Phone: Home:_____ **Cell:** _____ **Work:** _____

Birthdate:_____ **Male Female Email:** _____

Social Security Number: _____

Marital Status: Single Separated Divorced Married Widowed

Occupation:_____ **Employer:** _____

Contact Person(Spouse/Parent/Other)_____ **Employer/Emergency#**_____

Number of Children (Name & Ages) _____

Whom may we thank for referring you to our office? _____

or

How did you find out about us? Phonebook Saw our Sign Internet Search Insurance directory

Coupon/Mailing Met you at an event Other_____

Name of Medical Doctor: _____

Do Your Doctors know you are here today or utilize chiropractic? Yes No

Past Chiropractic Care? Yes No Doctor's Name: _____ **Last Visit:** _____

Please describe the reason for previous care: _____

1. **In general, would you say your health is (circle)**
   Excellent Very Good Good Fair Poor
2. **How would you say the health of your spine is?**
   Excellent Very Good Good Fair Poor

We offer many services, what are your goals by consulting with our office today? (Circle all that apply)

Relieve my symptoms Regain/Improve range of motion/joint function Learn exercises/stretches

Prevent future joint problems Improve sleep quality/quantity improve nutrition/diet

Were you injured? YES NO (If yes, please circle all that apply)

A work-related injury
An automobile accident
Personal Injury (Please describe below)

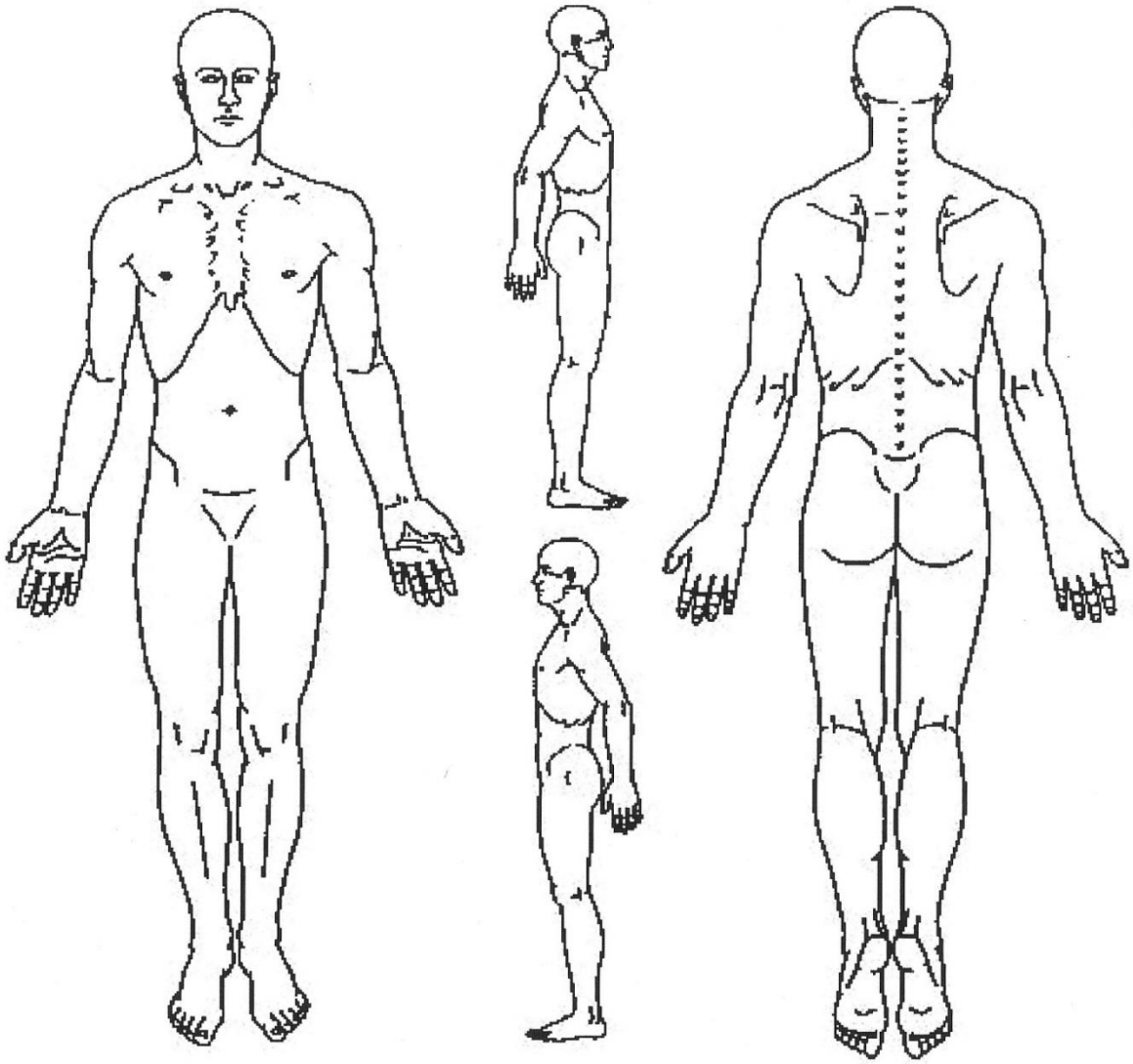
_____

_____

_____

AREAS OF COMPLAINT

Please mark on the diagram below the areas of your pain/symptoms



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

What types of treatment have you received? (Circle all that apply)

Cervical collar	Medication- muscle relaxers
Chiropractic care	Nerve blocks
Epidural steroid injections	Physical therapy
Extremity brace	Portable TENS unit
Lumbar (low back) corset/brace	Rhizotomy
Medication- prescription pain killer	Trigger point injections
Medication- anti-inflammatory	( ) I have not had treatment for this condition

If there are any other treatments not listed above, please write them below:

REVIEW OF SYMPTOMS

If you have an issue in a section below, circle your issue on the list. If you have none in the area, check "No problems"

Allergic/Immunity	***Bruising/Bleeding***	***Cardiovascular***	***Constitutional***
( ) No problems	***( ) No problems***	***( ) No problems***	***( ) No problems***
Allergies	Abnormal Bleeding	Ankle Swelling	Chills
Enlarged lymph nodes	Bruising	Chest pain	Decreased activity level
Hives	Cold Intolerance	Fainting	Fever
Hay fever	History of Anemia	Heart murmur	Fatigue
Persistent infections	Heat Intolerance	High Blood Pressure	Loss of appetite
		Palpitations	Loss of energy
		Shortness of Breath	Night sweats
		Varicose Veins	Uncontrolled sweating
			Weight gain
			Weight loss

Ears, Eyes, Nose, Throat	***Endocrine***	***Gastrointestinal***	***Genital-Urinary***
( ) No problems	***( ) No problems***	***( ) No problems***	***( ) No problems***
Bad breath	Diabetes	Bowel Dysfunction	Bed wetting
Blurred vision	Being excessively tired	Constipation	Burning with urination
Double vision	Loss of appetite	Diarrhea	Erectile dysfunction
Ear ringing – Tinnitus	Thyroid disorder	Excessive Belching after meals	Frequent urination
Eye pain	Unexplained weight loss/gain	Heartburn	Hesitancy
Hearing loss		Loss of bowel control	Losing control/incontinence
Hearing loss		Nausea	Nocturia
Sinus pain/pressure		Vomiting	Painful periods
Trouble swallowing			Sexual dysfunction
Work glasses/contacts			Trouble stopping/starting
Vision loss			Urgency

Integumentary/Skin	***Musculo-skeletal***	***Neurological***	***Psychological***
( )No problems	***( ) No problems***	***( ) No problems***	***( ) No problems***
Dryness	Joint pain	Abnormal sensory feelings in extremity	Anxiety
Hair/nail changes	Joint weakness	Dizziness/Vertigo	Depression
Itching	Low Back Pain	Loss of memory	Disturbed Sleep
Lesions	Muscle Tenderness	Seizures	Irritability
Open wound/infection	Muscle weakness	Ticks	Nervousness
Psoriasis	Neck Pain	Tremors	Suicidal thoughts
Rash	Pain between shoulder blades		
Strange Moles			

Respiratory	Shortness of Breath	Asthma	Congestion
( ) No problems	Coughing	Pain with breathing	Wheezing

PAST MEDICAL HISTORY

Please indicate any past or present medical health problems

☐ I am in good health

Indicate all past surgeries.

☐ I have no surgical history

Write all current medications & nutritional/herbal supplements as well as any allergies below:		
Medications/Supplements:	***Medications/Supplements:***	***Allergies:***
_____	_____	_____
_____	_____	_____
_____	_____	_____
☐ None at this time		☐ None at this time

SOCIAL HISTORY

Hand of Dominance	**Physical Work (typical day)**		**Mental Work (typical day)**	
Right	Light	Full Day	Light	Full Day
Left	Moderate		Moderate	
Ambidextrous	Heavy	Half Day	Heavy	Half Day

Hours of Sleep	**Highest Level of Education**	**International Travel**	**Work**
Less than 4	Did not graduate high school (or get GED)	Never	Part-time
4-5 hours	Earned a GED	Occasionally	
6-7 hours	Graduated high school	Frequently	Full-time
8-9 hours	Associates Degree	In the past	
10 or more hours	Bachelor's Degree		
	Master's Degree		
	PhD or Doctorate		

Types of Exercise		**Frequency of Exercise**	**Do you think you are overweight?**
Baseball	Lifting Weights		
Basketball	Running	Never	
Football	Soccer	Rarely	Yes
Golf	Tennis	Regularly	
Jogging	Swimming	Occasionally	No
	Yoga/Pilates		

Alcohol Consumption	**Recreational Drug Use**	**Caffeinated Beverages**
None	Never used	Never drinks
Rarely	Occasionally uses	Less than 1 a day
Occasionally	Often Uses	1-2 a day
Frequently	Has used in the last year	More than 2 a day
	Experimented in college years	

Years of Tobacco Use	**Cigarette Use**	**Chewing Tobacco**	**Cigars**
_____	Never smoked	Never chewed	Never smoked
	Smoked in the past, but quit	Chewed in the past, but quit	Smoked in the past, but quit
	Less than a ¼ pack/day	Occasionally chews	Occasionally smokes
	¼ pack/day	Often chews	Often smokes
	½ pack/day		
	1 pack or more/day		

Religious Preference: Yes _____ No Religious Preference

Have you served in the military?	**Branch**	**Did you serve during wartime?**	**Did you suffer trauma during your service?**
Yes	Army	Yes	Yes
	Navy		
	Air Force		
No	Marines	No	No
	Coast Guard		