



WELCOME

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID# _____

Patient Name _____
Last Name _____ First Name _____ Middle Initial _____

Address _____
Street _____ City _____ State _____ Zip _____

Email _____ Sex M F Age _____ Birthdate _____

Married Widowed Single Divorced Children Yes No How many? _____

Occupation _____ Patient Employer/School _____

Employer/School Address _____ Employer/School Phone (_____) _____

Spouse's Name _____ Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

CONTACT INFORMATION

Cell Phone (_____) _____

Phone Provider _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer

Workers' Comp. Other

Attorney Name (if applicable)

CHIROPRACTIC HISTORY

Have you been to the chiropractor before? Yes No

For what purpose? (Check all that apply)

Pain Relief Performance

Maintenance Wellness

PATIENT CONDITION

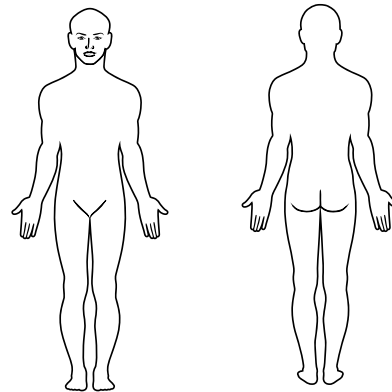
Reason for Visit? _____

When did your symptoms appear? _____

Is this condition getting progressively worse?

Yes No Unknown

Mark an **X** on the picture where you continue to have numbness, or tingling.



KEY

- P** = Pain
- N** = Numbness
- B** = Burning
- T** = Tingling
- Th** = Throbbing
- M** = Tightness

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). _____

How frequently do you have this pain? Constant

Frequent Occasional Intermittent

Does it interfere with your Work Sleep Daily Routine

Recreation How? _____

Activities or movements that are painful to perform.

Sitting Standing Walking Bending Lying Down

Squatting Lifting Overhead Driving



HEALTH HISTORY

TREATMENTS

What treatment have you already received for you condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____ When _____

Name and location of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tension Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
		High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

EXERCISE

None **What type(s)?**
 Minimal Weights
 Moderate Yoga
 Daily Running
 Heavy Other _____

WORKING ACTIVITY

Sitting Driving
 Standing Active
 Light Labor
 Heavy Labor

HABITS

Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee, Soda + Energy Drinks Cups/Day _____
 High Stress Level Reason _____

INJURIES/SURGERIES

DESCRIPTION

DATE

Previous Aches and Pains _____
 Head Injuries _____
 Broken Bones _____
 Dislocations _____
 Surgeries _____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

 Pharmacy Name _____
 Pharmacy Phone (_____) _____

 Dietary Habits _____
 Estimated Daily H2O: _____

TREATMENT GOALS

What are your goal(s) with treatment? _____
