

Patient Information

Date: _____

Patient Name: _____
Last Name

_____ First Name _____ Middle Initial

Address: _____

City: _____

State: _____ **Zip:** _____

E-Mail: _____

Sex: Male Female **Age:** _____

Birthdate: _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Spouse's Name: _____

Birthdate: _____

Do you have children? Yes No

If so, how many? _____

Occupation: _____

Patient Employer/School: _____

Employer/School Phone: (_____) _____

To whom may we thank for referring you? _____

Phone Numbers

Cell Phone: (____) _____

Home Phone: (____) _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Cell Phone: _____

Home Phone: _____

Accident Information

Is condition due to an accident? Yes No

Date of Accident: _____

Type of Accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp Other

Attorney Name (if applicable): _____

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 pain, numbness, or tingling.

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

Type of pain: Sharp Dull Throbbing Numbness Aching

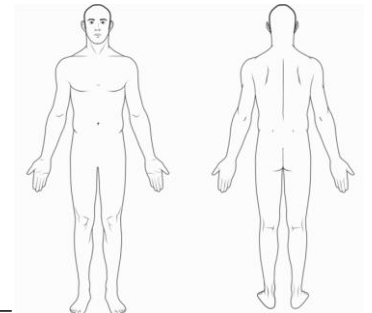
Shooting Burning Tingling Cramps Stiffness Swelling

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying down



Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Names of other doctors and/or facilities who have treated you for your condition: _____

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

Place a mark in the box, if you have had any of the following:

- | | | | |
|---------------------------------------------|-------------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> STI/STD |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage | Which one(s)? _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem | _____ |

Exercise

- None
- 1-2x/week
- 3-4x/week
- 5-7x/week

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Alcohol
- Coffee/Caffeine Drinks
- Fruits & Vegetables
- High Stress Level
- Water Intake

Drinks/Week: _____
 Cups/Day: _____
 Servings/Day: _____
 Reason: _____
 Ounces/Day: _____

Are you pregnant? Yes No

Due Date: _____

Injuries/Surgeries you have had...	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins/Herbs/Minerals

