



PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security # _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Ph# _____ Cell Ph# _____ Driver's License # _____

Marital Status: S M D W No. of Children: _____ Gender: F M

Emergency Contact: Name: _____ Relationship: _____

Phone No. _____

How did you hear of us? **Internet** **Billboard** **Phone Book** **Friend/Patient** **Other** _____

WORK INFORMATION

Name of Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ Contact Person _____

INSURANCE INFORMATION

Your Health Insurance Co. _____ Phone # _____

Member Name _____ Member ID _____ Group # _____

Date of Onset _____ Have you been treated for this condion? YES / NO Doctor's name _____

Doctors Location/Phone number _____

Briefly describe your condition _____

PATIENT'S SIGNATURE _____

DATE _____



MEDICAL HISTORY

Have you ever been hospitalized due to an accident or an illness? YES / NO If yes, please explain. _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.): _____

Have you recently notice any changes in you bodily function? i.e., intestinal/urinary functions, loss of weight, frequent dizziness, fatigue, nausea, vomiting, etc. YES / NO If yes, please explain: _____

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries before (include dates): _____

List any on the job injuries (include dates): _____

Have you had any broken bones? YES / NO if yes, please list and give dates: _____

Have you ever had done: ___ MRI ___ CT ___ X-Ray Associated with this injury? ___

List all current over-the-counter and prescription medication used (include reason used): _____

List any heath conditions that run in your family (cancer, diabetes, heart disease, etc.): _____

Have you been under physician's care in the past year? YES / NO (Reason) _____

When was your last physical examination? _____

Have you ever been under chiropractic care? YES / NO (DESCRIPTION/REASON) _____

If **female**, is there a possibility that you are pregnant? YES / NO

Are there any other additional health concerns or questions you have?

INITIALS: _____

Check any of the following symptoms you have noticed:

C: Current

P: Past

<u>Heart & Vascular</u>	C	P	<u>Mental Health</u>	C	P
Heart Disease			Irritability or Depression		
Dizziness			Anxiety		
Difficulty Breathing			Memory Loss		
Confusion			Difficulty Sleeping		
Shortness of Breath			Drug/ Alcohol Abuse		
Fatigue			Headaches		
Angina			Fainting		
High Blood Pressure					
Nausea			<u>Neuromusculoskeletal</u>	C	P
Vomiting			Neck Pain or Stiffness		
Thrombophlebitis			Shoulder Pain		
Cold Sweats			Arm/Hand Numbness/Tingling		
Light Headedness			Arm/Hand Fatigue/Weakness		
Severe Sudden Headaches			Leg/Foot Numbness/Tingling		
Sudden Weakness/ Numbness of Face, Arm, Leg, Esp. One Side			Leg/Foot Fatigue/Weakness		
Deep Leg Pain when Walking			Abdominal Pain		
			Mid Back Pain		
			Low Back Pain		
<u>Systemic Conditions</u>	C	P			
Pneumonia			Joint Pain Swelling/ Stiffness		
Emphysema			Pain with Exercise (Activity, Climbing, Stairs, etc)		
Chest Pain or Cough			Paralysis		
Gall Blander Disease			Muscle Weakness		
Kidney Stones					
Liver Disease			<u>Other</u>	C	P
Blood in Urine or Stool			Seizures		
Difficulty or Pain w/ Urination			Numbness/Tingling		
Fatigue or Loss of Energy			Jaw Pain, Clicking or Locking		
			Lumps (where?)		
<u>Ear, Nose, Throat, Eyes, Skin</u>	C	P	Diarrhea or Constipation		
Visual or Hearing Disturbance			Blood in Urine or Stool		
Rashes (Face, Body, Limps)			Difficulty or Pain w/ Urination		
Pain or Difficulty Swallowing			Lost of Appetite		
Sensitive to Light or Sound			Abnormal Menstrual Periods		

INITIALS: _____



(Please list all body parts separately: neck, back, low back, left leg, right hand, left thumb etc.)

1. Body part/ system _____

When did it start? _____

Level of pain? **Slight** 1 2 3 4 5 6 7 8 9 10 **Severe**

How often does it bother you? **Intermittent** **Constant**

Describe pain: **Sharp** **Dull** **Throbbing** **Burning** **Achy** **Excruciating**

Any lost of sensation? Yes / No If yes, where at? _____

Does the pain radiate? Yes / No If yes, where to? _____

What aggravates the symptoms? **Bending** **Lifting** **Sitting** **Walking** **Exercise** **Moving** **Sneezing** **Coughing**

Other _____

What helps the symptoms? **Medicine** **Hot Showers** **Rest** **Other:** _____

Any lost of sleep due to this condition? Yes / No

Stress cause by condition? Yes / No

Similar conditions in the past? Yes / No

2. Body part/ system _____

When did it start? _____

Level of pain? **Slight** 1 2 3 4 5 6 7 8 9 10 **Severe**

How often does it bother you? **Intermittent** **Constant**

Describe pain: **Sharp** **Dull** **Throbbing** **Burning** **Achy** **Excruciating**

Any lost of sensation? Yes / No If yes, where at? _____

Does the pain radiate? Yes / No If yes, where to? _____

What aggravates the symptoms? **Bending** **Lifting** **Sitting** **Walking** **Exercise** **Moving** **Sneezing** **Coughing**

Other _____

What helps the symptoms? **Medicine** **Hot Showers** **Rest** **Other:** _____

Any lost of sleep due to this condition? Yes / No

Stress cause by condition? Yes / No

Similar conditions in the past? Yes / No

3. Body part/ system _____

When did it start? _____

Level of pain? **Slight** 1 2 3 4 5 6 7 8 9 10 **Severe**

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Describe pain: **Sharp** **Dull** **Throbbing** **Burning** **Achy** **Excruciating**

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What aggravates the symptoms? **Bending** **Lifting** **Sitting** **Walking** **Exercise** **Moving** **Sneezing** **Coughing**

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What helps the symptoms? **Medicine** **Hot Showers** **Rest** **Other:** _____

Any lost of sleep due to this condition? Yes / No

Stress cause by condition? Yes / No

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INITIALS: _____