



PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Marital Status _____
H. Phone (_____) _____ Spouse Name _____
C. Phone (_____) _____ Number of Children _____
W. Phone (_____) _____ Referred by _____
E-mail _____ Insurance _____
Social Security# _____ Insured Name/DOB _____
Occupation _____ Present condition due to a work injury? __ Yes __ No
Employer _____ Present condition due to an auto injury? __ Yes __ No
Has the accident been reported? __ N/A __ Yes __ No

HEALTH HISTORY

Briefly describe your symptoms: _____

How did your symptoms start? _____

When did your symptoms start? _____

Average pain intensity (Please circle):

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**
Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

How often do you experience your symptoms?

- Constantly (76%-100% of the time)
- Frequently (51%-75% of the time)
- Occasionally (26%-50% of the time)
- Intermittently (0%-25% of the time)

How much have your symptoms interfered with your usual daily activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

In general, what would you say your overall health is right now?

- Excellent
- Very good
- Good
- Fair
- Poor

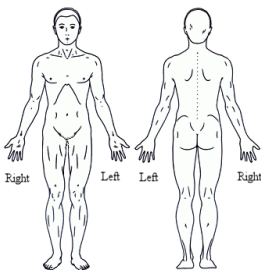
List any other doctors seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____

Does this pain shoot, radiate, or travel in your body? __ Yes __ No Where? _____

What makes your condition/pain better or worse? _____



Using the symbols below, mark on the pictures where you feel pain.

- Numbness == = =
- Dull Ache O O O
- Burning X X X
- Sharp/Stabbing / / /
- Pins, Needles + + +
- Other _____ ^ ^ ^

PLEASE COMPLETE BACK SIDE

MEDICAL HISTORY

Have you received chiropractic treatment previously? __ Yes __ No If yes, explain: _____

Do you smoke?__ Yes __ No Do you consume alcohol?__ Yes __ No Do you consume caffeine? __ Yes __ No

Please list ALL past accidents or injuries _____

Please list ALL past surgeries or illnesses _____

Please list ALL Medications/Supplements	Reason for Taking
_____	_____
_____	_____
_____	_____
_____	_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL CONDITIONS

- Y__ N__ Convulsions
- Y__ N__ Dizziness/Fainting
- Y__ N__ Headache/Migraine
- Y__ N__ Numbness/Tingling
- Y__ N__ Cancer
- Y__ N__ Diabetes
- Y__ N__ Thyroid Disease

MUSCLES & JOINTS

- Y__ N__ Low Back Problems
- Y__ N__ Neck Problems
- Y__ N__ Arm/Shoulder Pain
- Y__ N__ Leg Pain
- Y__ N__ Swollen Joints
- Y__ N__ Stiff/Painful Joints
- Y__ N__ Weak Muscles
- Y__ N__ Walking Problems
- Y__ N__ Sprains/Strains
- Y__ N__ Broken Bones

CARDIO-VASCULAR

- Y__ N__ High Blood Pressure
- Y__ N__ Heart Attack
- Y__ N__ Pain over Heart
- Y__ N__ Poor Circulation
- Y__ N__ Irregular Heartbeat
- Y__ N__ Strokes
- Y__ N__ Swelling Ankles
- Y__ N__ Varicose Veins

EAR/NOSE/THROAT

- Y__ N__ Earache/Ear Infection
- Y__ N__ Ear Noises/Ringing
- Y__ N__ Enlarged Thyroid
- Y__ N__ Frequent Colds
- Y__ N__ Hay Fever
- Y__ N__ Nasal Blockage
- Y__ N__ Nose Bleeds
- Y__ N__ Pain Behind Eyes
- Y__ N__ Poor Vision
- Y__ N__ Sore Throats
- Y__ N__ Tonsillitis

GASTRO-INTESTINAL

- Y__ N__ Excessive Gas
- Y__ N__ Constipation
- Y__ N__ Diarrhea
- Y__ N__ Excessive Thirst
- Y__ N__ Hemorrhoids
- Y__ N__ Liver Disease
- Y__ N__ Gallbladder Problems
- Y__ N__ Nausea
- Y__ N__ Abdominal Pain
- Y__ N__ Ulcer
- Y__ N__ Poor Appetite
- Y__ N__ Poor Digestion
- Y__ N__ Vomiting Blood
- Y__ N__ Black/Bloody Stool
- Y__ N__ Weight Loss/Gain

RESPIRATORY

- Y__ N__ Asthma
- Y__ N__ Chronic Cough
- Y__ N__ Difficulty Breathing
- Y__ N__ Coughing Blood
- Y__ N__ Coughing Phlegm

GENITO-URINARY

- Y__ N__ Blood in Urine
- Y__ N__ Frequent Urination
- Y__ N__ Kidney Infection
- Y__ N__ Painful Urination
- Y__ N__ Prostate Problems
- Y__ N__ Loss of Bladder Control

SKIN OR ALLERGIES

- Y__ N__ Bruising Easily
- Y__ N__ Eczema/Dermatitis
- Y__ N__ Hives
- Y__ N__ Itching
- Y__ N__ Allergy _____

FOR WOMEN ONLY

- Y__ N__ Birth Control _____
- Y__ N__ Hormone Replacement
- Y__ N__ Cramps/Backaches
- Y__ N__ Hot Flashes
- Y__ N__ Irregular Cycle
- Y__ N__ Miscarriage
- Y__ N__ Breast Pain
- Y__ N__ Pregnant at this Time

FAMILY HISTORY

	Heart Disease	Arthritis	Cancer	Diabetes	Back/Neck Problems	Other_____
Father's side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____