PATIENT INFORMATION

Date_____

Name_____

Address_____

City_____ State_____ Zip _____

Cell Phone _____ SS#_____

Birth Date___/____/____ Age _____ Sex _____

○Married ○Single ○Divorced ○Widowed

Whom may we thank for referring you? _____

What name do you prefer to be called? _____

May we add you to our email newsletter? Yes No

Email _____

EMPLOYMENT INFO

Occupation_____

Employer _____

Address_____

_____

Phone #_____

EMERGENCY INFO

Contact Name _____

Relationship_____

Phone # _____

Who is responsible for your bill, You and:

○Spouse ○Health Insurance ○Workers' Comp. ○Auto Insurance ○Medicare

Previous chiropractic care: ○None ○Doctor's name & approximate date of last visit _____

CURRENT HEALTH CONDITION

Chief Complaint: _____

When did the symptoms first appear? _____

Has this condition occurred before? ○Yes ○No

How often do you experience the symptoms?

○Constant 100% ○Frequent 75%

○Intermittent 50% ○Occasional 25% ○Rare 10%

What makes the symptoms worse? _____

What relieves the symptoms? _____

How would you describe the pain?

○Sharp ○Dull ○Aching ○Burning ○Numb

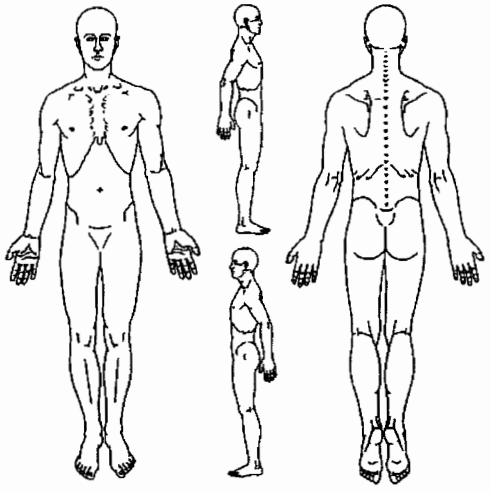
○Throbbing ○Radiating ○Deep ○Other_____

Rate the pain on a scale of 1-10 (10 being unbearable pain):

Right Now 1----2----3----4----5----6----7----8----9----10

At Its Worst 1----2----3----4----5----6----7----8----9----10

[Mark your areas of concern on figure]



Other Doctors Seen For This Condition: ○Yes ○No Who? _____

Type of treatment? _____ Results? _____

Is this condition: ○Job Related ○Auto Accident ○Home Injury ○Fall ○Other:_____

Do you wear a shoe lift? ○Yes ○No

Do you suffer from any condition other than that which you are now consulting us?

_____

_____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

○AIDS/HIV	○Arthritis	○Diabetes	○Gout	○Osteoporosis
○Anemia	○Cancer	○Epilepsy	○Multiple Sclerosis	○Rheumatic Fever

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

Musculoskeletal Code
○General Stiffness
○General Weakness
○Swollen Joints
○Spinal Curvature
○Neck Pain
○Arm Pain
○Pain Between Shoulders
○Low Back Pain
○Foot Trouble
○Walking Problems
○Jaw Problems

Nervous System Code
○Nervous
○Numbness
○Dizziness
○Forgetfulness
○Depression
○Cold/Tingling Extremities
○Stress
○Twitching

General Code
○Fatigue
○Allergies
○Headache
○Loss of Sleep
○Weight Loss
○Fever
○Thyroid Problems

Gastrointestinal Code
○Poor/Excessive Appetite
○Excessive Thirst
○Vomiting
○Nausea
○Diarrhea
○Constipation
○Liver Problems
○Gall Bladder Problems
○Abdominal Cramps
○Gas/Bloating/Belching
○Heartburn
○Black/Bloody Stools
○Colitis

C-V-R Code
○Chest Pain
○Short Breath
○Asthma
○Blood Pressure Problems
○Irregular Heartbeat
○Heart Problems
○Lung Problems
○Varicose Veins
○Ankle Swelling
○Stroke

EENT Code
○Vision Problems
○Dental Problems
○Sore Throat
○Ear Aches
○Hearing Difficulty
○Stuffed Nose
○Frequent Colds
○Nose Bleeds
○Sinus Trouble
○Hoarseness

Genitourinary Code
○Bladder Trouble
○Painful/Excessive Urine
○Discolored Urine

For Women Only
○Cramps
○Irregular Cycle
○Painful Periods
○Pregnant (now)

Family History
The following members have a same or similar problem as I do:
○Father
○Mother
○Brother
○Sister
○Child
○Other_____

Please list ALL medications and/or vitamins you take

Name_____ For What_____ Name_____ For What_____

Name_____ For What_____ Name_____ For What_____

Name_____ For What_____ Name_____ For What_____

METHOD OF PAYMENT ○Cash ○Check ○Credit/Debit

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

DO NOT WRITE BELOW THIS LINE

Doctor Review of Systems: _____ Date:_____