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CONFIDENTIAL PATIENT INFORMATION

Name____ Date ____________________________________
Home Ph.______________________________________ Cell Ph.__________________________________
Address ______________________________City _______________ Zip __________ S.S.#________________
Age _________ Birth Date ____________________ Marital Status M S W D How many children? ___________
Occupation___________________________ Employer_________________ Office Ph. ___________________
Work Address____ Email Address________________________
Name of Spouse ___________________ Occupation ___________________ Employer___________________

Emergency Contact______________________Phone (_____)____

How did you hear about us?____

Your Age___________ Height________ft.__________in. Weight______________lbs

Chiropractors you have seen before:
Name_______________________________________City____________________State____When____________
Name_______________________________________City____________________State____When____________

List medical doctors seen within past year:
Name_______________________________________City____________________State____When____________
Name_______________________________________City____________________State____When____________
Date of last physical examination____

X-Rays (last taken and body region)____
MRI (last taken and body region)____

List all surgeries:
Type____When____________
Type____When____________
Type____When____________

Past accidents or injuries:
Type____When__________Hospitalized? Yes_____No______
Type____When__________Hospitalized? Yes_____No______
Type____When__________Hospitalized? Yes_____No______

PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT

Please describe your primary complaint: ____

When did it start? ______________ Have you had it in the past: ☐ Y ☐ N When: __________

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _______________

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _________________

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _________________

What makes it better: _________________________ Worse:__________________________

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

If yes, to either question above, please explain: ________________________________

What other treatment have you had for this condition: ____________________________

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other __________________________

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull

L R R L

SECONDARY CONDITION (If Applicable)

Please describe your secondary complaint: ____

When did it start? ______________ Have you had it in the past: ☐ Y ☐ N When: __________

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _______________

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _________________

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _________________

What makes it better: _________________________ Worse:__________________________

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

If yes, to either question above, please explain: ________________________________

What other treatment have you had for this condition: ____________________________

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other __________________________

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull

L R R L

ADDITIONAL CONDITION (If applicable)

Please describe any additional complaint: ____

When did it start? ______________ Have you had it in the past: ☐ Y ☐ N When: __________

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _______________

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _________________

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _________________

What makes it better: _________________________ Worse:__________________________

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

If yes, to either question above, please explain: ________________________________

What other treatment have you had for this condition: ____________________________

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other __________________________

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull

L R R L

Please circle the following activities are affected by your current condition.

Bathing	Cooking	Laying down	Sleep
Bending	Daily pet care	Lifting items	Sneezing
Brushing teeth	Dressing	Reading	Sports
Caring for family	Swallowing	Reaching	Static sitting
Carrying items	Driving	Running	Static standing
Changing of pos.	Eating	Shaving	Washing body/hair
Climbing stairs	Exercising	Showering	Work activities
Computer use	Getting out of bed	Sexual activities	Yard work
Concentration	Household chores		

Past and Present Conditions

Past	Musculoskeletal	Present
[ ]	Neck pain	[ ]
[ ]	Shoulder pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand pain	[ ]
[ ]	Upper back pain	[ ]
[ ]	Low back pain	[ ]
[ ]	Leg pain	[ ]
[ ]	Knee pain	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw pain	[ ]
[ ]	Swelling in joints (list joints) ____________________	[ ]
[ ]	Stiffness of joints (list joints) ____________________	[ ]

Past	Nervous System	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bedwetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear pain	[ ]
[ ]	Impaired vision	[ ]
[ ]	Eye pain	[ ]
[ ]	Paralysis	[ ]

Past	Cardiovascular	Present
[ ]	Rapid heart beat	[ ]
[ ]	Chest pains	[ ]

Past	Endocrine	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	Respiratory	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic pain	[ ]
[ ]	Chronic cough	[ ]
[ ]	Sinusitis	[ ]

Past	Gynecologic	Present
[ ]	Cramps	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal symptoms	[ ]

Past	Genito-Urinary	Present
[ ]	Painful urination	[ ]
[ ]	Loss of bladder control	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	GI Tract	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	Skin	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Please check any of the following that apply to you.

- [ ] Tobacco
- [ ] Alcohol
- [ ] Tranquilizers/Sedatives
- [ ] Laxatives
- [ ] Coffee, cups/day ____________
- [ ] Regular soda, cans/day ________
- [ ] Diet soda, cans/day ____________
- [ ] Water ____________________

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Past	Condition	Present
[ ]	Hemorrhoids	[ ]
[ ]	Rheumatic heart disease	[ ]
[ ]	High blood pressure	[ ]
[ ]	Angina	[ ]
[ ]	Heart attack	[ ]
[ ]	Stroke	[ ]
[ ]	Asthma	[ ]
[ ]	Gallbladder	[ ]
[ ]	Cancer	[ ]
[ ]	HIV positive/AIDS	[ ]
[ ]	Emphysema	[ ]
[ ]	Arthritis	[ ]
[ ]	Drug or alcohol dependency	[ ]
[ ]	Diabetes	[ ]
[ ]	Ulcer	[ ]
[ ]	Kidney stones	[ ]
[ ]	Bladder infection	[ ]
[ ]	Allergies	[ ]
[ ]	Other____________	[ ]
[ ]	Other____________	[ ]

Family History: Insert age and check any box that applies

	Age (if living)	Heart Dx	High Cholest	High Bl Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Bck Pain	Carpal Tunnel	Head aches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other ____												

How many hours of sleep do you get per night ________Type of mattress___________________________________
How old is your mattress _____________ How many pillows do you sleep with________________________________
Do you sleep on your: _______Side _______Stomach _______Back
Do you: _______ watch TV in Bed _______Read in bed _______ use a laptop in bed
How many hours a day do you spend on the computer _____Does sitting at the computer bother your condition_____

Do you wear: _____ Arch Supports _____Heal Lifts _____Inserts _____Orthotics _____Braces ______Supports
If so please explain ____
Do you: ______Run ______Bike ______Swim ______ Work Out ______Yoga ______Play other sports
How much and how often do you exercise____
____
____
Is your current condition interfering with your exercise program and if so how _________________________
____
____
If you don't or can't exercise at the moment, what are your future exercise goals_______________________
____
____

List medications and/or vitamins & minerals you are taking:
Type____For________________________How long___________
Type____For________________________How long___________
Type____For________________________How long___________
Type____For________________________How long___________
Type____For________________________How long___________
Type____For________________________How long___________
Type____For________________________How long___________
Type____For________________________How long___________

"I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that payment for services rendered is due at the time of service unless other arrangements are made."

Patient Signature____ Date_________________
Guardian or Spouse's Signature Authorizing Care______________________________ Date_________________
Information Taken By____ Date__________________