PATIENT INFORMATION

General Information

First Name _____
Middle Initial _____
Last Name _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Email Address _____
Birthdate _____
Social Security _____

Sex Male ○ Female ○
Race American Indian ○ Alaska Native ○ Asian ○
African American ○ Native Hawaiian ○ White ○
Other Pacific Islander ○ Declined to State ○
Ethnicity Declined to State ○ Non Hispanic or Latino ○
Hispanic or Latino ○
Language English ○ Spanish ○ French ○ Other: _____
Marital Status Single Married Other _____
Referred By _____
Work Status Employed ○ Full-time student ○ Part-time student ○
Appt Reminder None ○ Phone Call ○ Text ○ E-mail ○

For Office Use Only
Account Number _____
Diagnosis Codes _____
Charges _____

Insured's Information

Patient is the: Same/Self Spouse Child Other of Insured
Please present your insurance card so we can keep a copy.

Employer Information

Employer Name_____

Condition Information

Related to Employment Yes ○ No ○
Related to Auto Accident Yes ○ No ○
- If yes, name of Auto Issurance Co. _____
Related to Persona Injury Case Yes ○ No ○
- If yes, name of lawyer: _____

Height _____ Approx. Weight _____

Where do you hurt?_____When did it start?_____
How did it happen?_____
What makes it feel better?_____ Worse?_____
Frequency of pain: Constant-100% of time ○ Frequent-75% of time ○ Intermittant-50% of time ○ Occasional-25% of time ○
What type of pain is it? Achy ○ Sharp ○ Dull ○ Burning ○ Shooting ○ Throbbing ○ Numb ○ Tingling ○ Other:_____

List symptoms individually: Choose the severity level associated with each

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe

List any tests, studies or medications received for this condition:
❑X-ray/MRI: _____
❑Medications: _____
Have you ever been to a chiropractor? _____

Where you admitted to the hospital due to this condition: ❑Yes ❑No
If yes, what hospital? _____Transported by? ❑Ambulance ❑Police ❑Other:_____
Date Admitted: _____ Date Released: _____ Length of Stay: _____
List the hospital procedures received:

_____

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: _____ To: _____

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No

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HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker

❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No See attached photocopy ☐

Medication: _____
Route: Oral Intravenous
Frequency: _____
Began Use: _____

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Route: Oral Intravenous
Frequency: _____
Began Use: _____

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Route: Oral Intravenous
Frequency: _____
Began Use: _____

Medication: _____
Route: Oral Intravenous
Frequency: _____
Began Use: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____ Medication: _____
Reaction: _____ Reaction: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

OTHER SYMPTOMS

GENERAL SYMPTOMS

- ❑ Allergy to: ____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux

NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?
- _____ Last Pap Date
- _____ Last Mens. Cycl

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ Date: _____