

# PATIENT INFORMATION

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

SS# \_\_\_\_\_ MARTIAL STATUS M S D W --- WHAT DO YOU PREFER TO BE CALLED? \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE/PAGER: \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ @ \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ WK# \_\_\_\_\_

INSURANCE NAME \_\_\_\_\_ POLICY # \_\_\_\_\_

REASON FOR TODAY'S VISIT (CHIEF COMPLAINT): \_\_\_\_\_

WHAT CAUSED YOUR CONDITION (be as specific as possible) \_\_\_\_\_

WHEN DID YOUR CONDITION FIRST APPEAR?(specific date, days ago, weeks ago, etc) \_\_\_\_\_

SINCE THE ONSET OF YOUR PROBLEM IS IT: GETTING WORSE( ) STAYING SAME( ) SLOW TO IMPROVE( )

DOES IT INTERFERE WITH: WORK( ) SLEEP( ) DAILY ROUTINES( ) OTHER \_\_\_\_\_

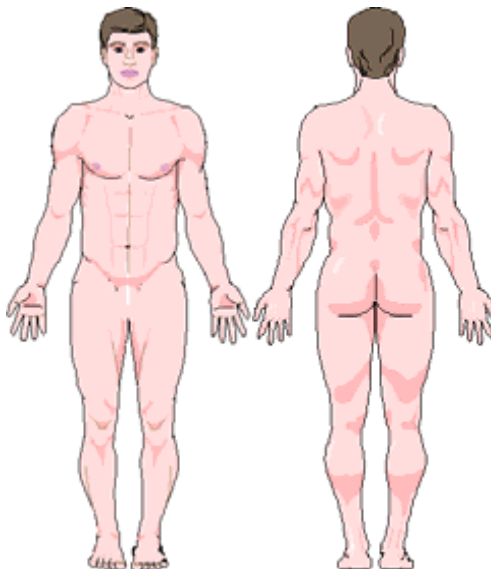
HOW OFTEN DOES IT OCCUR? CONSTANT / ALWAYS THERE( ) COMES AND GOES( ) OTHER \_\_\_\_\_

DOES THE CONDITION RADIATE TO THE ARMS OR LEGS? YES( ) NO( )  
IF YES, WHERE AND HOW FREQUENTLY \_\_\_\_\_

DO YOU HAVE: NUMBNESS( ) TINGLING( ) WEAKNESS( ) OTHER \_\_\_\_\_

LIST AND MARK THE SEVERITY OF YOUR CONDITION ON THE SCALES BELOW:

BODY PART _____	0(NONE)	5	(SEVERE)10
BODY PART _____	0(NONE)	5	(SEVERE)10



TYPE OF PAIN: ACHING( ) BURNING( ) DULL( ) NUMB( ) SHARP( ) SHOOTING( )

THROBBING( ) TINGLING( ) OTHER \_\_\_\_\_

WHAT ACTIVITIES OR POSITIONS AGGRAVATE YOUR CONDITION? BENDING( ) COUGHING( ) TURNING HEAD( )

GETTING UP/DOWN( ) LIFTING( ) LYING DOWN( ) REACHING( ) SITTING( ) SNEEZING( )

STANDING( ) STRAINING TO STOOL( ) DRIVING( ) TWISTING( ) WALKING( ) OTHER \_\_\_\_\_

HAVE YOU EVER HAD THIS CONDITION BEFORE? YES( ) NO( ) IF YES WHEN? \_\_\_\_\_

WHAT ACTIVITIES OR POSITIONS RELIEVE YOUR CONDITION? HEAT( ) ICE( ) LYING DOWN( )

MEDICATION( ) SITTING( ) STANDING( ) STRETCHING( ) OTHER:

WHO IS YOUR PRIMARY PHYSICIAN? \_\_\_\_\_ PH# \_\_\_\_\_

HAVE ANY OTHER DOCTOR'S SEEN YOU FOR YOUR CURRENT CONDITION? \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING FOR ANY REASON? IF **YES** PLEASE ADD APPROX LAST VISIT DATE

ACUPUNCTURE\_\_\_\_/\_\_\_\_ PHYSICAL THERAPY\_\_\_\_/\_\_\_\_ MASSAGE\_\_\_\_/\_\_\_\_

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? \_\_\_\_\_ IF YES BY WHOM? \_\_\_\_\_

REASON FOR TREATMENT? \_\_\_\_\_ WHEN WAS THE LAST VISIT? \_\_\_\_\_

CIRCLE ANY OF THE FOLLOWING YOU'VE HAD: ADJUSTMENTS BY HAND----ADJUSTMENTS BY INSTRUMENT---- HEAT

ELECTRICAL STIMULATION----ICE/COLD----ULTRASOUND----EXERCISE REHAB----OTHER \_\_\_\_\_

SATISFACTION WITH CARE PROVIDED? (CIRCLE ONE)---VERY SATISFIED---SOMEWHAT SATISFIED---

SOMEWHAT DISSATISFIED---NOT SATISFIED---COMMENTS ON THAT CARE: \_\_\_\_\_

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS? \_\_\_ANTI-DEPRESANTS \_\_\_BLOOD THINNERS

\_\_\_TRANQUILIZERS \_\_\_INSULIN \_\_\_ASPRIN/TYLENOL/ETC. \_\_\_MUSCLE RELAXANTS

\_\_\_ANTI INFLAMMATORIES \_\_\_PAIN KILLERS \_\_\_OTHERS (list) \_\_\_\_\_

PLEASE LIST **ANY** SERIOUS MEDICAL CONDITIONS YOU HAVE OR HAD: \_\_\_\_\_

PLEASE LIST **ANY** SUGERIES (even if unrelated) AND APPROXIMATE AGES \_\_\_\_\_

LIST **ANY** PAST ACCIDENTS (even if not injured) WITH DATES: \_\_\_\_\_

FAMILY HEALTH HISTORY (MOTHER, FATHER, SISTER, BROTHER) PLEASE CIRCLE:

ARTHRITIS CANCER DIABETES HEART DISEASE BACK PROBLEMS STROKE

DO YOU SMOKE: PKS/DAY\_\_\_\_ FOR\_\_\_\_ YEARS ALCOHOL: DRINKS / WEEK\_\_\_\_ CAFFEINE: CUPS / OZ / DAY\_\_\_\_

HOW IS YOUR ENERGY OVERALL? FULL POWER( ) OK( ) LOW( ) SPORADIC/GENERALLY FATIGUED( )

HOW DO YOU FEEL YOUR IMMUNE SYSTEM IS? STRONG( ) OK( ) LOW( )

THIS OFFICE PROVIDES SERVICES IN ADDITION TO CONVENTIONAL CHIROPRACTIC TREATMENT.  
PLEASE INDICATE YOUR INTEREST IN THE FOLLOWING BY PLACING A CHECK IN THE APPROPRIATE BOX.

SERVICE	INTERESTED	NOT INTERESTED	WOULD LIKE TO DISCUSS WITH DR.
ACUPUNCTURE			
ALTERNATIVE MEDICINE			
BODY PURIFICATION / DETOX PROGRAMS			
CARPAL TUNNEL- NON SURGICAL TREATMENTS			
HEADACHE / MIGRAINE-NATURAL SOLUTIONS			
MASSAGE THERAPY			
NEUROMUSCULAR THERAPY			
NUTRITIONAL HEALTH ASSESMENT			
SPINAL DECOMPRESSION			

**FOR WOMEN ONLY:**

ARE YOU PREGNANT \_\_\_\_\_ DUE DATE \_\_\_\_\_ ARE YOU NURSING \_\_\_\_\_

ARE YOU TAKING BIRTH CONTROL \_\_\_\_\_ 1<sup>ST</sup> DATE OF LAST CYCLE \_\_\_\_\_

THE INFORMATION PROVIDED IN THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_