

PATIENT INFORMATION

ACCT# _____

Last Name _____
 Address _____
 City _____ State _____ Zip _____
 Occupation _____
 Employer _____
 Home Phone # _____ Work Phone # _____
 Email Address _____
 Spouse Name _____
 Occupation _____
 Employer _____
 Children (Name/Age) _____

First Name _____ Middle Initial _____
 SS# _____ Birth Date _____ Age _____
 Male Female Marital Status: S M W D Separated
 Health Insurance _____
 Insurance/Policy # _____
 Cell Phone # _____
 Emergency Contact _____
 Phone# _____
 Relationship _____
 Referred by _____

CURRENT COMPLAINTS

Please list your major complaints

	How long have you had this problem?	Is it getting better (B) worse (W) or same (S)	Is it constant (CS) or comes & goes (CG)?
1) _____	_____	B W S	CS CG
2) _____	_____	B W S	CS CG
3) _____	_____	B W S	CS CG

Did your injury occur While at work? Motor vehicle accident?
 Is this condition NEW OLD Was it treated before YES NO
 If treated before, what was done? _____
 Names of Doctors _____
 Medications you currently take _____

HEALTH STATUS REVIEW

Please check all current and past conditions, even if they don't seem related to your complaint.

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> High/low blood Pressure |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Asthma | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Numb arms/hands | <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Numb legs/feet | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> General stiffness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Eczema/Shingles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Knee problems | <input type="checkbox"/> Fatigue/Tired | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Other _____ | | |

PAIN LOCATION & TYPE

Using the codes below, please mark on the drawing to indicate where your pain is and what you are feeling.

R **L** **L** **R**

Sharp
x x

Burning
+ +

Dull Pain
√ √

Pins & Needles
○ ○

Numb
● ●

Women only: Do any of the following apply to you?

- Pregnant? Yes No Painful periods? Yes No
 Nursing? Yes No Irregular cycles? Yes No
 Birth control? Yes No Breast implants? Yes No

CHIROPRACTIC EXPERIENCE

Have you ever had Chiropractic care before? YES NO
 NAME OF DOCTOR _____ DATE _____

 Date of last spinal X-rays or other X-rays _____

HEALTH CARE GOALS

Describe how your current health complaints interfere with the different areas of your life: Work, Family, Relationships, Sports, Hobbies, House work, etc.

When was the last time you felt your best? _____
 On a scale of 1-10 (1 is low, 10 is high)
 Where would you rate your overall health, including physical, mental, nutritional, stress and energy? _____
 What level of overall health would you like to have? _____

HEALTH HISTORY

From birth to present, please list by date and describe any car accidents, work-related, recreational, athletic or other injuries.

Have you ever been hospitalized? YES NO
 List any Surgeries

Patient Signature _____

Date _____

Last _____ First _____ Acct # _____

FAMILY HISTORY:

List any significant family health history by family member. (i.e. mother-high blood pressure)

None Mother _____ Father _____
Brother _____ Sister _____
Other _____

LIFESTYLE QUESTIONNAIRE:

Stress Factors:

Current Weight _____ Have you recently lost or gained weight? Y N
On a scale of 1-10, rate your stress level (1 = no stress and 10 = severe stress) _____.
Rate your overall energy level on a scale of 1-10 (1 = no energy and 10 = maximum energy) _____.
Average number of hours of sleep per night during the work week _____ and on the weekend _____.
Problems sleeping: None Getting to sleep Staying asleep Feeling tired upon waking

Nutrition Habits:

Tobacco use: None Current: amount per day _____ Past
Alcohol use: None Occasional Moderate Excessive
Beer _____ servings per week
Wine _____ servings per week
Other Liquor _____ servings per week
Caffeine use per day: None Coffee ____ cups Tea ____ cups Soda ____ Energy drinks ____
Soda pop ounces per day: None Diet _____ oz Regular _____ oz

Vitamins/Supplements: None Daily Occasional: (please indicate products currently taking)
Multi Omega-3 Calcium Magnesium Probiotics B-Complex Vitamin C
Other _____

Ounces of water (non-carbonated) consumed per day _____.
On average how many meals do you eat per day _____.

Physical Activity:

The majority of my day is spent: Sitting Standing Bending Lifting Computer/Desk work
Other _____
My normal daily activity level is: None Minimal Moderate Strenuous
Regular Exercise: None Occasional 1-2x/wk 3-4/wk 5-6x/wk Daily (Please give brief description)

Do you wear orthotics in your shoes? Y N Do you use a heel lift or have a short leg? Y N

REASON FOR SEEKING CARE:

Please let us know how we can best help you reach your goals.

A: Pain/Symptom Relief B: Improve Structure and Function C: Optimal Health and Wellness
D: All of the above

Patient Signature _____ Date _____