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Patient Data

Date: _____

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss ☐Dr. (check one)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Cell Phone: (_____)_____-_____

Date of Birth: _____/_____/_____ **Sex:** ☐Male ☐Female **Email:** _____

Social Security Number: _____-_____-_____ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐Yes ☐ No

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Spouse's Date of Birth _____/_____/_____ **Spouse's SS#** _____-_____-_____

Insurance

Subscriber's Name: _____ **Date of Birth** _____/_____/_____

Relationship to patient: _____

Insurance Co. : _____ **Group #:** _____

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Employer Data

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____-_____

Children Data

Name: First **Middle** **Last** **D.O.B.**

1. _____

2. _____

3. _____

4. _____

_____

_____

_____

_____

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Is it okay to call you at work?

☐ Yes ☐ No

How did you hear about our clinic? Or who referred you?

☐ Family member	☐ Attorney	☐ Internet web site	☐ Health class
☐ Friend	☐ Yellow Pages	☐ Billboard	☐ Brochure
☐ Physician	☐ Newspaper ad	☐ TV Commercial	☐ Direct mail ad
☐ Employer	☐ Sign on building	☐ Radio	☐ Other

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Health History/Medical Conditions: Mark all that apply & add "C" for current, "R" for resolved and "O" for ongoing.

☐ Alcoholsim	☐ Emphysema	☐ High Cholesterol	☐ Prostate Problems
☐ Anemia	☐ Epilepsy	☐ Kidney Disease	☐ Prosthesis
☐ Anorexia/Bulimia	☐ Eye Condition	☐ Liver Disease	☐ Psychiatric Illness
☐ Arthritis	☐ Fibromyalgia	☐ Lupus	☐ Scoliosis
☐ Asthma	☐ Fractures	☐ Lyme Disease	☐ Skin Disorders
☐ Back/Neck Condition	☐ Gall Bladder Disease	☐ Miscarriage	☐ Stroke
☐ Bleeding Disorders	☐ Gout	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Breast Lump	☐ Headaches	☐ Neurological Condition	☐ Tuberculosis
☐ Cancer	☐ Heart/Vascular Disease	☐ Osteoporosis	☐ Ulcers
☐ Chemical Dependency	☐ Hepatitis	☐ Pacemaker	☐ Urinary Tract Infections
☐ Chicken Pox	☐ Hernia	☐ Parkinson's Disease	☐ Venereal Disease
☐ Depression/Anxiety	☐ Herniated Disk	☐ Pinched Nerve	☐ Other
☐ Diabetes	☐ High Blood Pressure	☐ Polio	☐ Other

Surgeries:

☐ Abdominal/ Gastrointestinal	☐ Cardiovascular procedure	☐ Joint procedure	☐ Prostate/ Genitourinary
☐ Back surgery	☐ Gynecological /Genitourinary	☐ Neck surgery	☐ Skin procedures
☐ Other			

Allergies:

☐ Environmental	☐ Latex	☐ Seasonal	☐ Other
☐ Food	☐ Medications	☐ Other	☐ Other

Social History:

☐ Caffeine:	never	moderately	frequently	☐ Tobacco:	never	moderately	frequently
☐ Alcohol :	never	moderately	frequently	☐ Stress:	never	moderately	frequently
☐ Exercise:	never	moderately	frequently	☐ Other			

Family History:

☐ Arthritis	☐ Cancer	☐ Cholesterol	☐ Diabetes
☐ Heart problems	☐ High blood pressure	☐ Psychiatric	☐ Stroke
☐ Thyroid	☐ Other		

Medications, Nutritional Supplements & Substance Use/Exposure:

☐ Alcohol	☐ Inhaled drugs/medications
☐ Intravenous (IV) drugs/medications	☐ Occupational
☐ Second hand smoke	☐ Other

Oral Drugs/Medications/Nutritional Supplements:

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Occupational Activities:

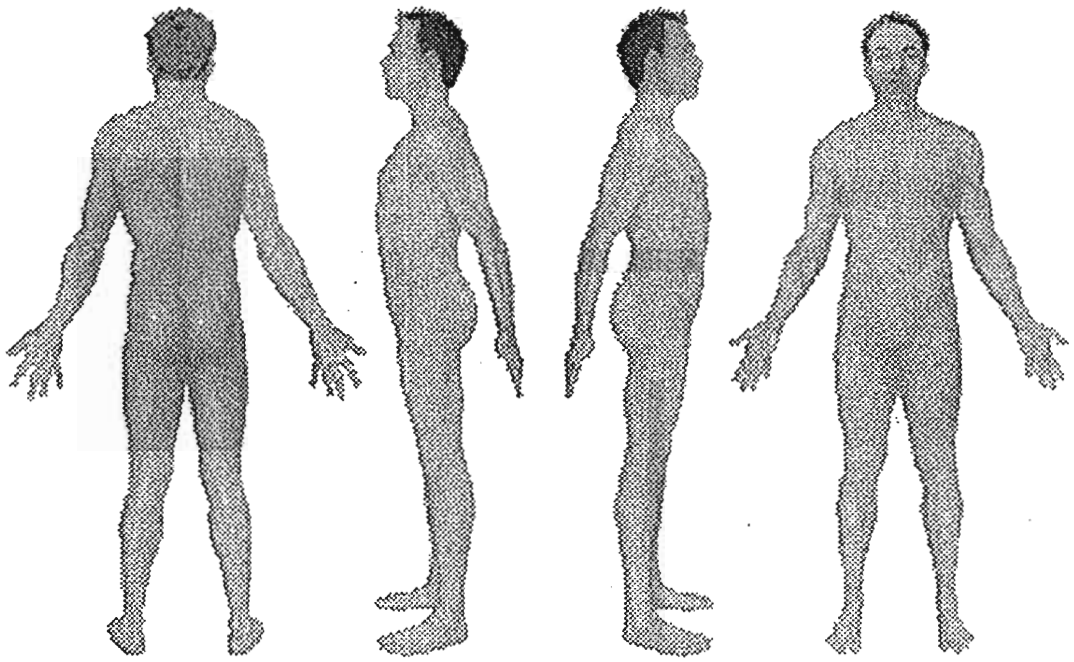
☐ Administration	☐ Business owner	☐ Clerical/secretarial	☐ Computer user
☐ Construction	☐ Daycare/childcare	☐ Executive/legal	☐ Food service industry
☐ Health care	☐ Heavy equipment operator	☐ Heavy manual labor	☐ Home services
☐ Household	☐ Light manual labor	☐ Manufacturing	☐ Medium manual labor

Daily Activities:

☐ Sitting:	never	moderately	frequently	☐ Standing:	never	moderately	frequently
☐ Walking:	never	moderately	frequently	☐ Bending:	never	moderately	frequently
☐ Light Lifting:	never	moderately	frequently	☐ Operate Machinery:	never	moderately	frequently
☐ Heavy Lifting:	never	moderately	frequently	☐ Overhead Work:	never	moderately	frequently
☐ Reaching:	never	moderately	frequently	☐ Computer Use:	never	moderately	frequently

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms: _____

_____

When did your symptoms start? **Month** _____ **Day** _____ **Year** _____

How did your symptoms begin? _____

Is your condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other _____

To whom have you reported your accident?

☐ Auto Insurance ☐ Employer ☐ Workers Comp. ☐ Other _____

Attorney Name (if applicable) _____

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How often do you experience your symptoms?			
☐ Constantly (76-100% of the day)	☐ Frequently (51-75% of the day)	☐ Occasionally (26-50% of the day)	☐ Intermittently (0-25% of the day)
What describes the nature of your symptoms?			
☐ Sharp	☐ Dull ache	☐ Numb	☐ Shooting
☐ Burning	☐ Tingling	☐ Stabbing	
How are your symptoms changing?			
☐ Getting better	☐ Not changing	☐ Getting worse	
During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)			
☐ 0 None	☐ 1	☐ 2	☐ 3
☐ 4	☐ 5	☐ 6	☐ 7
☐ 8	☐ 9	☐ 10 Unbearable	
During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):			
☐ Not at all	☐ A little bit	☐ Moderately	☐ Quite a bit
☐ Extremely			
During the past 4 weeks, how much of the time has your condition interfered with your social activities?			
☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time
☐ None of the time			
In general, would you say your overall health right now is....			
☐ Excellent	☐ Very good	☐ Good	☐ Fair
☐ Poor			
Who have you seen for your symptoms:			
☐ No one	☐ Other Chiropractor	☐ Medical Doctor	☐ Physical Therapist
☐ Other			
What treatment did you receive for your symptoms?			
☐ Adjustments	☐ Physical Therapy	☐ Medication	☐ Surgery
☐ Other			
When did you receive this treatment?			
☐ In the last month	☐ 2-3 months ago	☐ 3-6 months ago	☐ 6 months to 1 year ago
☐ 1-2 years ago	☐ 2-5 years ago	☐ 5-10 years ago	
What tests have you had for your symptoms?			
☐ X-rays	☐ MRI	☐ CT Scan	☐ Other
When were these tests done?			
☐ In the last month	☐ 2-3 months ago	☐ 3-6 months ago	☐ 6 months to 1 year ago
☐ 1 - 2 years ago	☐ 2-5 years ago	☐ 5-10 years ago	
Have you had similar symptoms in the past?			
☐ Yes ☐ No			
If you have had or received treatment in the past for the same or similar symptoms, who did you see?			
☐ This Office	☐ Other Chiropractor	☐ Medical Doctor	☐ Physical Therapist
☐ Other			
What is your occupation?			
☐ Professional/Executive	☐ White Collar/Secretarial	☐ Tradesperson	☐ Laborer
☐ Homemaker	☐ Full-Time Student	☐ Retired	☐ Other
If you are not retired, a homemaker or a student, what is your work status?			
☐ Full-time	☐ Part-time	☐ Self-employed	☐ Unemployed
☐ Off work	☐ Other		

Thank you. Please return to the front desk.