

PATIENT INFORMATION *all fields required*

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

Name you go by: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Last 4 of social: xxx-xx-_____ Email: _____

Marital Status: Single Married Widowed

Spouse's Name: _____ # of Children _____

How did you hear about our office/who referred you? _____

PHONE NUMBERS

Home: _____ Cell: _____

Preferred appointment reminder: Email Cell

In case of emergency, notify: _____ Relationship: _____ Phone: _____

PATIENT CONDITION

Chiropractic care is for optimal health and healing. However, most of our patients first seek our help when in a health crisis. What health concerns or crisis brought you to our office?

Reason for Visit _____

Is this due to an accident or injury? Yes No Type of Accident: Auto Home Other: _____

Is your condition getting worse? Yes No Has your condition been treated in the past by a doctor? Yes No

How long have you had the above problems? (If accident or injury, write date) _____

How often do you have the above problems? (Choose one)

Weekly 25% of day 50% of day 75% of day Constant/Daily

Rate your pain intensity from (circle) None 1 2 3 4 5 6 7 8 9 10 Severe

Does your pain interfere with your:

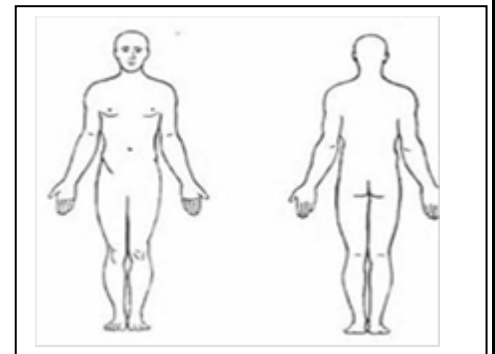
Daily Activities Work Sleep Other _____

What aggravates your pain?:

Bending Standing Sitting Walking Recreation

Describe your pain: sharp dull throbbing burning numb achy tingling radiating

What makes your condition better? _____ worse? _____



HEALTH HISTORY

PLEASE CHECK ANY AND ALL PROBLEMS YOU HAVE HAD IN THE **LAST 2 YEARS**:

General

- Headaches
- Migraines
- Anxiety/Nervousness
- Depression
- Dizziness
- Insomnia
- Fatigue
- Seizures
- Ringing in Ears
- Blurred Vision
- Sinus/Allergy Issues
- Cancer

Cardiovascular

- Heart Attack/Stroke
- High Blood Pressure
- Irregular Heartbeat
- High Cholesterol

Musculoskeletal

- Arthritis
- Scoliosis
- Swollen Joints
- Muscle Spasms
- Tingling/Numbness
- Muscle Weakness
- Radiating Pains
- Arm/Hand Pain
- Leg/Feet Pain

GU/GI

- Bowel Changes
- Bladder Changes
- Constipation
- Digestive Issues
- GERD/Reflux
- Prostate/Menstrual Changes

Other

- Leg Cramping
- Fibromyalgia
- Ear Infections/Aches
- Herniated Disc
- Pinched Nerve

Any Other?

List Medications:

INSURANCE INFORMATION

Primary Insurance: _____ Policy No: _____ Group No: _____

Primary Subscriber Name: _____ Primary Subscriber DOB: _____

Secondary Insurance: _____ Policy No: _____

WORK & FAMILY HISTORY

Work related injuries can cause serious spinal problems. What is your occupation? _____

Any past or present health problems or diagnosis in another family member(s)? Yes No

If YES, please explain: _____

FEMALES ONLY

Spinal health is especially important during pregnancy. Is there any chance you are pregnant? Yes No

If YES, due date: _____ If NO, are you on Birth Control Pills? Yes No

Check if any apply: irregular menses severe menses miscarriage fertility challenges

Signature

Date