

CONFIDENTIAL PATIENT INFORMATION

Name _____ Date _____
Home Ph. _____ Cell Ph. _____
Address _____ City _____ Zip _____ S.S.# _____
Age _____ Birth Date _____ Marital Status M S W D How many children? _____
Occupation _____ Employer _____ Office Ph. _____
Work Address _____ Email Address _____
Name of Spouse _____ Occupation _____ Employer _____

Emergency Contact _____ Phone (____) _____
Whom may we thank for referring you to us/how did you hear about us? _____

Your Age _____ Height _____ ft _____ in. Weight _____ lbs

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____
Name _____ City _____ State _____ When _____

List medical doctors seen within past year:

Name _____ City _____ State _____ When _____
Name _____ City _____ State _____ When _____
Date of last physical examination _____

List all surgeries:

Type _____ When _____
Type _____ When _____
Type _____ When _____

Past accidents or injuries:

Type _____ When _____ Hospitalized? Yes _____ No _____
Type _____ When _____ Hospitalized? Yes _____ No _____
Type _____ When _____ Hospitalized? Yes _____ No _____

PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT

Please describe your primary complaint: _____

When did it start? _____ Have you had it in the past: Y N When: _____

Please check the appropriate box: The pain is constant it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

Sharp/Stabbing Burning Dull Tingling Numbness Other _____

Does your pain travel from the point of pain? Y N If yes, where: _____

Have you seen any other doctors for this condition: Y N Name: _____

What makes it better: _____ Worse: _____

Do any of the following aggravate your condition? Walking Sitting Coughing

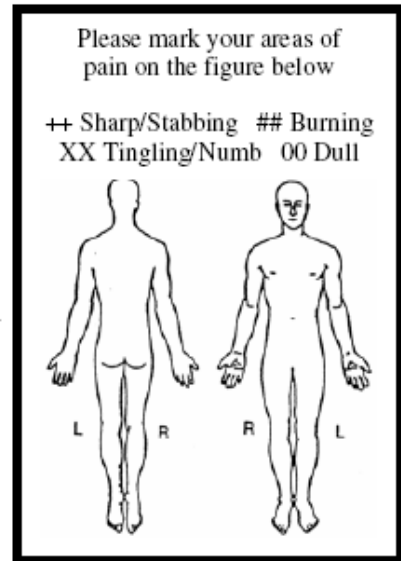
Sneezing Driving Breathing Working Bowel Movements Sleeping

Is this the result of an automobile accident: Y N Work related injury: Y N

If yes, to either question above, please explain: _____

What other treatment have you had for this condition: _____

Chiropractic Physical Therapy Surgery Other _____



SECONDARY CONDITION (If Applicable)

Please describe your secondary complaint: _____

When did it start? _____ Have you had it in the past: Y N When: _____

Please check the appropriate box: The pain is constant it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

Sharp/Stabbing Burning Dull Tingling Numbness Other _____

Does your pain travel from the point of pain? Y N If yes, where: _____

Have you seen any other doctors for this condition: Y N Name: _____

What makes it better: _____ Worse: _____

Do any of the following aggravate your condition? Walking Sitting Coughing

Sneezing Driving Breathing Working Bowel Movements Sleeping

Is this the result of an automobile accident: Y N Work related injury: Y N

If yes, to either question above, please explain: _____

What other treatment have you had for this condition: _____

Chiropractic Physical Therapy Surgery Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull

ADDITIONAL CONDITION (If applicable)

Please describe any additional complaint: _____

When did it start? _____ Have you had it in the past: Y N When: _____

Please check the appropriate box: The pain is constant it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

Sharp/Stabbing Burning Dull Tingling Numbness Other _____

Does your pain travel from the point of pain? Y N If yes, where: _____

Have you seen any other doctors for this condition: Y N Name: _____

What makes it better: _____ Worse: _____

Do any of the following aggravate your condition? Walking Sitting Coughing

Sneezing Driving Breathing Working Bowel Movements Sleeping

Is this the result of an automobile accident: Y N Work related injury: Y N

If yes, to either question above, please explain: _____

What other treatment have you had for this condition: _____

Chiropractic Physical Therapy Surgery Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull

Please circle the following activities are affected by your current condition.

Bathing

Cooking

Laying down

Sleep

Bending

Daily pet care

Lifting items

Sneezing

Brushing teeth

Dressing

Reading

Sports

Caring for family

Swallowing

Reaching

Static sitting

Carrying items

Driving

Running

Static standing

Changing of pos.

Eating

Shaving

Washing body/hair

Climbing stairs

Exercising

Showering

Work activities

Computer use

Getting out of bed

Sexual activities

Yard work

Concentration

Household chores

How many hours of sleep do you get per night _____ Type of mattress _____
 How old is your mattress _____ How many pillows do you sleep with _____
 Do you sleep on your: _____ Side _____ Stomach _____ Back _____
 Do you: _____ watch TV in Bed _____ Read in bed _____ use a laptop in bed _____
 How many hours a day do you spend on the computer _____ Does sitting at the computer bother your condition _____

Do you wear: _____ Arch Supports _____ Heal Lifts _____ Inserts _____ Orthotics _____ Braces _____ Supports _____
 If so please explain _____
 Do you: _____ Run _____ Bike _____ Swim _____ Work Out _____ Yoga _____ Play other sports _____
 How much and how often do you exercise _____

 Is your current condition interfering with your exercise program and if so how _____

 If you don't or can't exercise at the moment, what are your future exercise goals _____

List medications and/or vitamins & minerals you are taking:

Type _____	For _____	How long _____
Type _____	For _____	How long _____
Type _____	For _____	How long _____
Type _____	For _____	How long _____
Type _____	For _____	How long _____
Type _____	For _____	How long _____
Type _____	For _____	How long _____
Type _____	For _____	How long _____

"I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that payment for services rendered is due at the time of service unless other arrangements are made."

Patient Signature _____ Date _____
 Guardian or Spouse's Signature Authorizing Care _____ Date _____
 Information Taken By _____ Date _____