

Patient Data:

Date: _____

Title: Mr. Mrs. Ms. Miss Dr. (circle one)

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

Address Line 1: _____

Address Line 2: _____

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

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

Cell Phone: (____) _____ - _____ **Is it okay to call you at work?** Yes No

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

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

Spouse Name: _____ N/A

Emergency Contact:

Contact Name: _____

Contact Phone: (____) _____ - _____

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

Employer Data:

Name: _____

Address Line 1: _____

Address Line 2: _____

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

Occupation: _____

Primary Care Physician:

Name: _____ **Phone:** (____) _____ - _____

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

How did you hear about our clinic? Or who referred you? Name: _____

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Employer | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Google ad |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> Health class | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other |

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

	No _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Vascular Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary:

	No _____		
	Present	Past	No
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stone			

Hematologic/Lymphatic:

	No _____		
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Psychiatric:

	No _____		
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional:

	No _____		
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Surgeries

Appendectomy	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>
Cardiovascular Procedure	<input type="checkbox"/>
Laminectomy	<input type="checkbox"/>
Cervical Disc Procedure	<input type="checkbox"/>

Respiratory:

	No _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Chronic Cough			
Sleep Apnea			

Ears/Nose/Throat:

	No _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Problems			
Nosebleed			
Difficulty Swallowing			

Eyes:

	No _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary:

	No _____		
	Present	Past	No
Skin Lesions			
Skin Ulcers			
Eczema			
Psoriasis			
Rashes			

Neurologic:

	No _____		
	Present	Past	No
Babinski			
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Carpal Tunnel			
Spinning/Balance			

Allergies

Eggs	<input type="checkbox"/>
Soy	<input type="checkbox"/>
Fish or Shellfish	<input type="checkbox"/>
Sulfites	<input type="checkbox"/>
Milk or Lactose	<input type="checkbox"/>
Wheat/Gluten	<input type="checkbox"/>
Peanuts	<input type="checkbox"/>

Allergic/Immunologic:

	No _____		
	Present	Past	No
Immune Disorder			
HIV/AIDS			
Cortisone Use			

Gastrointestinal:

	No _____		
	Present	Past	No
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal:

	No _____		
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine:

	No _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Menopausal			
Menstrual Problems			
Menstrual Cramping			

Medications / Supplements

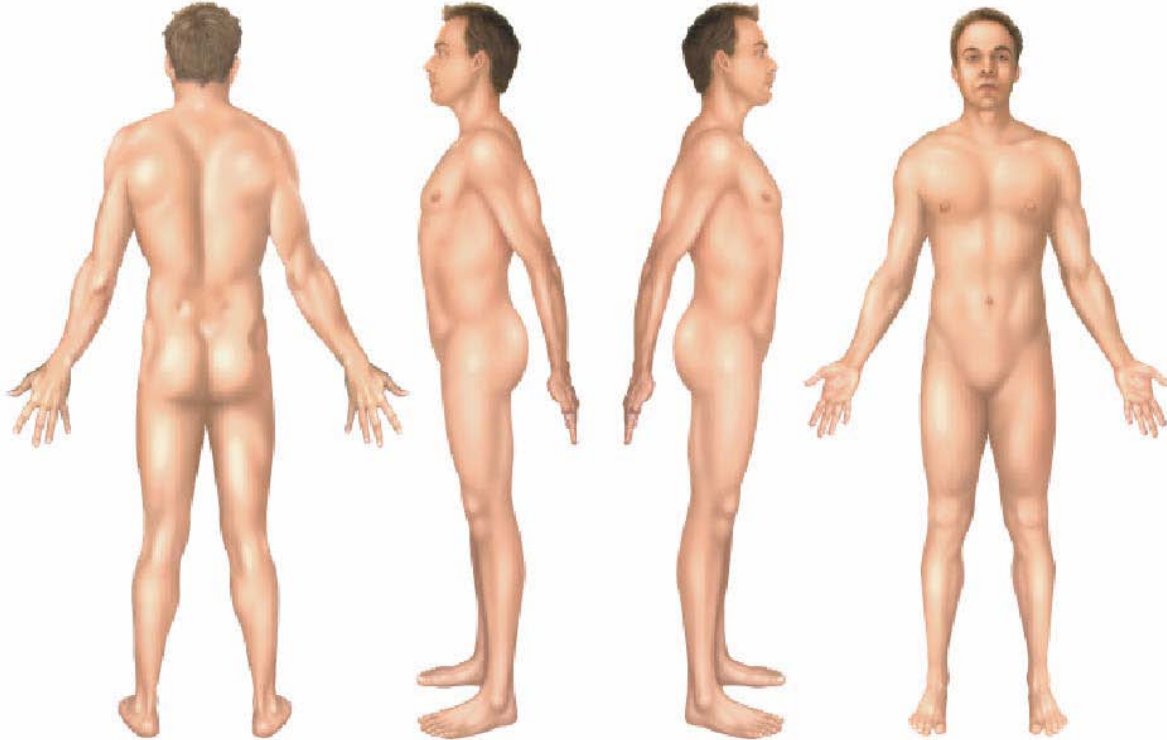
Cholesterol/Statins	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Ibuprofen	<input type="checkbox"/>
Narcotic Pain Meds	<input type="checkbox"/>
Multivitamin	<input type="checkbox"/>

Family History (circle Parent or Sibling)

Arthritis (Parent/Sibling)	<input type="checkbox"/>
Cholesterol (Parent/Sibling)	<input type="checkbox"/>
Heart Problems (Parent/Sibling)	<input type="checkbox"/>
Cancer (Parent/Sibling)	<input type="checkbox"/>
Diabetes (Parent/Sibling)	<input type="checkbox"/>
High Blood Pressure (Parent/Sibling)	<input type="checkbox"/>
Stroke (Parent/Sibling)	<input type="checkbox"/>

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



Have you seen a chiropractor in the past? No Yes When: _____

For what condition? _____

For the following questions (1-13), answer the questions for your main (chief) complaint.
(For example: neck pain or back pain). Area: _____

1. During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Trip to ER)

- | | | | |
|---------------------------------|---------------------------------------|--|----------------------------|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 |
| <input type="checkbox"/> 8 | <input type="checkbox"/> 9 Unbearable | <input type="checkbox"/> 10 Trip to ER | |

2. How did your symptoms begin? _____

3. When did your symptoms start? Month _____ Day _____ Year _____

4. How often do you experience your symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

4A. Are your symptoms worse: in the morning by midday at the end of the day at night throughout day

5. What describes the nature of your symptoms?

- | | | | |
|---|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> dull | <input type="checkbox"/> sharp | <input type="checkbox"/> sharp with movement | <input type="checkbox"/> throbbing |
| <input type="checkbox"/> burning | <input type="checkbox"/> deep | <input type="checkbox"/> aching | <input type="checkbox"/> tingling |
| <input type="checkbox"/> stabbing | <input type="checkbox"/> cramping | <input type="checkbox"/> pinprick | <input type="checkbox"/> numbness |
| <input type="checkbox"/> radiating type of pain | | | |

6. Are your symptoms radiating? Yes No

Describe: _____

7. What activities aggravate your pain?

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> sitting | <input type="checkbox"/> standing | <input type="checkbox"/> walking |
| <input type="checkbox"/> bending | <input type="checkbox"/> stooping | <input type="checkbox"/> lifting |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> sneezing | <input type="checkbox"/> coughing |
| <input type="checkbox"/> straining | <input type="checkbox"/> twisting | <input type="checkbox"/> reaching |
| <input type="checkbox"/> looking up | <input type="checkbox"/> looking down | <input type="checkbox"/> movement |
| <input type="checkbox"/> rest | <input type="checkbox"/> laying on back | <input type="checkbox"/> driving |
| <input type="checkbox"/> typing | <input type="checkbox"/> scooping | <input type="checkbox"/> household chores |
| <input type="checkbox"/> exercise | <input type="checkbox"/> stair stepping | <input type="checkbox"/> Nothing aggravates it |

Other: _____

8. What activities relieve your pain?

- | | | |
|--|---|---|
| <input type="checkbox"/> sitting | <input type="checkbox"/> standing | <input type="checkbox"/> laying down |
| <input type="checkbox"/> knees are bent up | <input type="checkbox"/> rest occurs | <input type="checkbox"/> leaning against a support |
| <input type="checkbox"/> movement occurs | <input type="checkbox"/> no movement occurs | <input type="checkbox"/> analgesic topical pain relief gel is applied |
| <input type="checkbox"/> ice is applied | <input type="checkbox"/> heat is applied | <input type="checkbox"/> Nothing relieves it |
| <input type="checkbox"/> ibuprofen is taken | <input type="checkbox"/> medication is used | |
| <input type="checkbox"/> stretching/exercise is used | <input type="checkbox"/> adjustments are provided | |

Other: _____

9. Have you had any weakness, related to your complaint, in your arms/hands/legs/feet?

Describe _____ Yes No

10. Have you had any bowel/bladder changes, since this complaint began? Yes No

11. Have you seen anyone in the past for this complaint? Yes No

Who? _____

12. Have you had any tests (radiology) done for this complaint? Yes No

What? _____

13. Have you had any major trauma in your past? Yes No

10. What do you hope to gain from your chiropractic care? _____

11. Do you have a goal of losing weight or would you like diet information? Yes No
