

PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms. _____

Last

Legal First

Middle Initial

Name you prefer to be called (nickname): _____ Social Security #: _____

Phone #: () _____ Fax #: () _____ Cell #: () _____

E-mail: _____ Driver's License #: _____

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

Age: _____ Birth Date: _____ Sex: _____ Patient's Employer: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Phone #: () _____ Ext: _____ Occupation: _____

Please circle: single/married/domestic partners/divorced/other: _____ Spouse/partner's name: _____

Note: Fill out this section only if insured is different than patient. Name of Insured: _____

Relationship to insured: (please circle one): spouse/domestic partner child other: _____

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

Social Security #: _____ Phone #: () _____ Birth Date: _____

Insured's Employer (if different from patient): _____ Phone #: () _____

Work Address: _____ City: _____ State: _____ Zip: _____

PERSONAL HEALTH HISTORY

Have you ever been to a chiropractor before? No/Yes, what for? _____

Who referred you to our practice? Person: _____ Advertisement: _____

Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes

What do you hope to do better or enjoy more when you regain your health? _____

When was your last physical exam? _____ Results: _____

Date, and results, if known, of any recent tests: cholesterol: _____ other: _____

Please list all current medications, vitamin/mineral supplements, herbs, including dosage: _____

List any known allergies: _____

If you smoke or have ever smoked, describe how much, and for how long: _____

Describe your recreational drug use: _____ typical alcohol intake (#of drinks per day/per week): _____

Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.): _____

Please list and describe all significant previous surgeries: _____

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session: _____

CHIEF COMPLAINT

Name: _____ Date: _____ Condition #: _____ (use separate form for each condition)

1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury someone else might be legally liable for? Yes/No Please Initial: _____ If yes, please fill out accident-specific form at the front desk
2. Please describe the nature of your condition at this time: _____

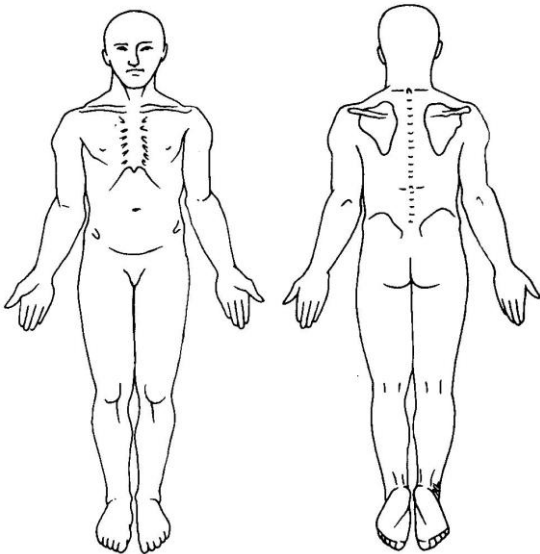
3. When did your condition first begin? Year: _____ Month: _____ Day/Date: _____ Time: _____
4. Cause of condition (circle all that apply): auto accident work injury sudden trauma reoccurrence repetitive trauma unknown/gradual other explain: _____
5. Have you had anything like this before? No/Yes: when?: _____
6. How often does the problem re-occur?: _____
7. Is the pain (circle): constant, on & off, usually lasting: ___ minutes ___ hours ___ days ___ weeks other: _____
8. Lately, has the pain been(circle): getting better getting worse staying about the same
9. Does the pain radiate?, to where: _____
10. What makes it feel better? _____
11. What makes it feel worse? _____
12. If you have seen another professional for this problem, or done any self-care, describe the type of treatment and results: _____

13. At what time of day, week, or setting (home, recreation, work) is your pain worst? _____
14. Please list any activities you are unable to perform/have not performed due to the pain, or for fear of making the pain worse?

15. What else would you like the Dr. to know about you and/or your condition: _____

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:

ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST

1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY

1 2 3 4 5 6 7 8 9 10

FAMILY HISTORY

Please list any significant health problems of parents, grandparents, or siblings: _____

REVIEW OF SYSTEMS

Please write a **number** in the spaces below: 1. presently have 2. previously had 3. related to accident

GENERAL

- _____ Frequent or recurring Chills
- _____ Epilepsy/Convulsions/Seizure
- _____ Frequent or recurring Dizziness
- _____ Frequent or recurring Fainting
- _____ Frequent or recurring Fatigue
- _____ Frequent or recurring Fever
- _____ Headache
- _____ Frequent or recurring Sleep loss
- _____ Recent Weight Change
- _____ Anxiety/Panic Attacks
- _____ Depression
- _____ Frequent or recurring Sweats
- _____ Frequent/recurring hives/rashes
- _____ Frequent/recurring colds/flu
- _____ Vertigo
- _____ Fainting
- _____ Fears/Phobias

GENITO-URINARY/ENDOCRINE

- _____ Bedwetting
- _____ Frequent urination
- _____ Urinary tract infections
- _____ Painful urination
- _____ Painful menstruation
- _____ Prostate trouble
- _____ Loss of bowel/bladder control
- _____ Gall Stones
- _____ Blood in urine
- _____ Thyroid problems/Goiter
- _____ Kidney stones
- _____ Irregular menstrual cycle
- _____ Hot flashes
- _____ Diabetes
- _____ Pelvic Inflamm. Dis.
- _____ Infertility/Miscarriage

RESPIRATORY

- _____ Spitting up phlegm
- _____ Chest pain
- _____ Spitting up blood
- _____ Difficult breathing
- _____ Asthma
- _____ Wheezing
- _____ Chronic cough
- _____ Allergies

GASTROINTESTINAL

- _____ Bloating, belching, gas
- _____ Esophageal reflux
- _____ Constipation
- _____ Frequent heartburn
- _____ Ulcer
- _____ Digestive Problems
- _____ Parasites
- _____ Pain over stomach
- _____ Diarrhea
- _____ Vomiting
- _____ Nausea
- _____ Poor appetite
- _____ Candida/Yeast
- _____ Hernia

CARDIOVASCULAR

- _____ Hardening of arteries
- _____ High blood pressure
- _____ Pain over heart
- _____ Bad circulation/ankle swell
- _____ Rapid heart beat
- _____ Heart Disease
- _____ Palpitation/Ireg heart beat
- _____ Cold Hands &/or Feet

EYES, EARS, NOSE, THROAT

- _____ Frequent/recurring sore throat
- _____ Deafness
- _____ Dental problems
- _____ Ear problems/Infections
- _____ Sinus problems
- _____ Frequent/recurring nose bleeds
- _____ Vision problems
- _____ Canker sores
- _____ Cold sores

MUSCULOSKELETAL – pain, numbness, weakness in:

- _____ Low Back
- _____ Neck
- _____ Upper Back
- _____ Mid Back
- _____ Between Shoulder Blades
- _____ Shoulder Blade: R/L both
- _____ Shoulder: R/L both
- _____ Foot: R/L bunions/corns
- _____ Fibromyalgia
- _____ Arm: R/L both
- _____ Elbow: R/L both
- _____ Hand: R/L both
- _____ Leg: R/L both
- _____ Hip: R/L both
- _____ Knee: R/L both
- _____ Ankle: R/L both
- _____ Spinal curvature
- _____ Arthritis/Gout

OTHER

- _____ Abscesses
- _____ Acne
- _____ Alcohol/Drug Addiction
- _____ Anemia
- _____ Athlete's Foot/Fungal infection
- _____ Cancer
- _____ Chicken Pox
- _____ Eczema
- _____ Genital Warts
- _____ Warts
- _____ Hepatitis
- _____ Scarlet Fever
- _____ HIV
- _____ Chicken Pox
- _____ Dry/Cracked heels

OTHER

- _____ Mononucleosis
- _____ Psoriasis
- _____ Sexually Transmitted Disease
- _____ Whooping Cough
- _____ Ingrown Toenails/Hang-nails

OTHER

- _____ Genital Herpes
- _____ Pneumonia
- _____ Sexual Abuse
- _____ Worms
- _____ Teeth Problems/Cavities

OTHER

- _____ Mumps
- _____ Root Canal/gum disease
- _____ Stroke
- _____ Shingles
- _____ Penile/Vaginal Discharge

OPTIONAL SECTION: NUTRITION

Height: _____ Present Weight: _____ Weight one year ago: _____ Preferred Weight: _____

Please indicate which you eat on a typical day: { } Breakfast { } Lunch { } Dinner # of snacks/day: _____

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

- | | | | |
|------------------|---------------------------|--|---------------------------------|
| _____ Eggs | _____ Red Meat | _____ Fruits | _____ Fats/Oils: |
| _____ Cheese | _____ Pork | _____ Vegetables | _____ Canola _____ Corn |
| _____ Skim Milk | _____ Fish | _____ Desserts | _____ Olive _____ Peanut |
| _____ 1% Milk | _____ Ham | _____ Grains, Rice, Pasta, Cereal, Bread | _____ Safflower _____ Sunflower |
| _____ 2% Milk | _____ Beans | _____ Butter | Other: _____ |
| _____ Whole Milk | _____ Chicken/Turkey | _____ Margarine | _____ Other: _____ |
| _____ Yogurt | _____ Tofu/Soy | _____ Nuts/Seeds/Peanut Butter | _____ Bacon/Hot Dogs, etc. |
| Other: _____ | _____ Sausage/Lunch Meats | Other: _____ | _____ Spicy Foods |

Please indicate the estimated # of servings (6-8 oz. cups) of each of the following, which you drink on a typical day:

- | | | | |
|----------------------------|---------------------------|--------------------------------------|--------------|
| _____ Caffeinated Coffee | _____ Regular Soft Drinks | _____ Water | Other: _____ |
| _____ Decaffeinated Coffee | _____ Diet Soft Drinks | _____ Fruit Juices | Other: _____ |
| _____ Regular Tea | _____ Herbal Tea | _____ Sports Drinks (i.e., Gatorade) | Other: _____ |

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet: _____

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: _____

Was your special diet prescribed by a physician or nutritionist? Yes _____ No _____

Do you have success in following your special diet? Yes _____ No _____ explain: _____