

Date: _____

CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Gender: M / F Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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

Height: _____ Weight: _____ Age: _____ Date of Birth: _____ SS#: _____

Marital Status: Married Single Widow(er) Divorced **Pregnant?** Yes / No Unsure **No. of Children:** _____

Name of Spouse or Guardian: _____ Phone #: _____

Circle: Rt Handed / Lt Handed/ Ambidextrous **Alcohol:** Yes / No Amt: _____ **Smoker:** Yes / No Amt: _____

Occupation: _____ Employer: _____

Employer Phone: _____ Emergency Contact: _____

Relationship: _____ Phone #: _____

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend or Family Member Name _____ OR

- Yellow Pages
- Website
- Presentation
- Sign
- Newspaper
- Other _____

I. Health Complaints

I have no health complaints, I am interested in prevention and health maintenance (skip to section II.)

What is your **primary** complaint? _____

List other health complaints on the following lines:

- 2 _____ 3 _____
- 4 _____ 5 _____
- 6 _____ 7 _____

How long have you been experiencing the **primary** complaint? _____

How does the **primary** complaint feel? dull sharp numb tingling burning spasm other _____

How often do you experience the **primary** complaint? constantly daily weekly monthly yearly

What makes your **primary** complaint better? _____ worse? _____

Have you missed any work or school because of your **primary** complaint? yes no

How does your **primary** complaint affect you at home/work/school? _____

Have you had any prior treatment for your **primary** complaint? _____

What do you believe is causing your **primary** complaint? _____

Please mark the areas of all of your complaints on the diagrams below.

Pain severity:

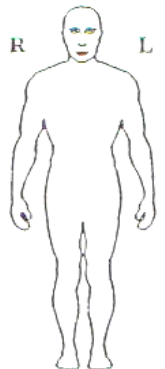
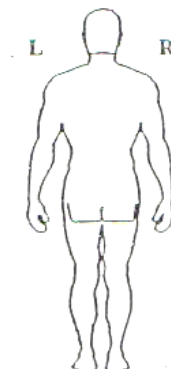
If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain **over the last 2 weeks:**

Please rate your pain **RIGHT NOW:** _____ / 10

Please rate your pain when it is at its **WORST:** _____ / 10

Please rate your pain when it is at its **BEST:** _____ / 10

Please rate your pain when it is at its **AVERAGE:** _____ / 10



II. Hospitalization, Surgeries and Injuries

Do you have a pacemaker? yes no

Have you had knee or hip replacement surgery? yes no

Have you had breast implant surgery? yes no

Do you have any other implantable medical device in your body? yes no

Please list any hospitalizations, surgeries, auto accidents, job injuries, sports injuries or injuries that you have had:

Date /Description

1 _____
2 _____
3 _____
4 _____
5 _____

Chiropractic Doctors consulted in the past year:

Name: _____ Approximate Date of last visit: _____

Have you ever been diagnosed with having problems with any of the following (if yes to any, please indicate when)?

- | | | | | |
|--------------------------------------|------------------------------------|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Weight | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Digestion | <input type="checkbox"/> Liver | <input type="checkbox"/> Spine/Back |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Lungs | <input type="checkbox"/> Circulation | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Stomach | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Ovaries | <input type="checkbox"/> PMS | <input type="checkbox"/> Spleen | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Breast | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Colon | <input type="checkbox"/> Constipation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Edema | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Tumors | |

III. Medications and Supplements

Are medications (prescription or over-the-counter) necessary for you to have relief and/or to function yes no

Do you use an inhaler or nebulizer? yes no What type? _____ How often? _____

Please list any medications (prescription and over the counter) and/or supplements you are currently taking and why:

1 _____ 5 _____
2 _____ 6 _____
3 _____ 7 _____
4 _____ 8 _____

IV. Genetic History

Have any of your blood relatives had any of the following conditions? If yes, please list who.

Heart Disease _____ Stroke _____
Cancer _____ Arthritis _____
Diabetes _____ Auto-Immune Disease _____

V. ASSIGNMENT & RELEASE

Please Initial:

_____ I authorize the taking of photographs and x-rays to be used for treatment purposes.
_____ I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

Patient's Signature: _____ Date: _____