



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 #: _____

Reason for appointment & related health problems:	Date condition started or for how long?	Have you had this before?	Injury related?
1. _____	_____	Yes No	Yes No
2. _____	_____	Yes No	Yes No
3. _____	_____	Yes No	Yes No

How did you hear about us?

- Referred by _____
- Health Screen (where?) _____
- Phone Book _____
- Internet (how?) _____
- Other _____

Health Interests: (What would you like more information about?)

- Back Pain & Sciatica
- Headaches
- Neck Pain
- Diet & Nutrition
- Weight Loss
- Food Allergies
- Women's Health
- Kid's Health
- Exercise & Fitness
- Wellness

HISTORY OF PRIMARY COMPLAINT

What is the reason you are being seen in the clinic today? _____

Body Part Effected: _____ Right Left Both Sides

Date of injury/Onset: _____

Is this the first time you have had this pain? Yes / No If No, when was the FIRST time you had these same symptoms?

What testing or treatments have you tried to date with location of those tests and treatments:

How did the CURRENT episode of pain/discomfort occur?

How did the FIRST episode of pain/discomfort occur?

Bladder Function: If you have had any change in your bladder function, do you:

- Urinate more often
- Have a sense of urgency
- Have a loss of sensation around the groin or buttocks
- Have loss of control or accidents
- Have problems with sexual function

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

What makes your pain DIMINISH? (check all that apply):

- Nothing
- Ice
- Heat
- Massage/Rubbing
- Rest
- Exercise/Activity
- Sitting
- Laying
- Standing
- Bracing/taping
- Stretching
- "Popping" the joints
- Other: _____
- Over-The-Counter Medications (which ones _____)
- Prescription Medications (which ones _____)
- Other: _____

What makes your pain WORSE? (check all that apply):

- Coughing
- Sneezing
- Bearing Down
- Lifting
- Bending
- Pushing
- Pulling
- Driving
- Sitting
- Walking
- Running
- Standing
- Movement of the head
- Movement of the low back
- Laying down
- Other: _____

Pain Quality: How would you describe your pain/discomfort (check all that apply):

- Dull
- Achy
- Throbbing
- Stiff
- Sharp
- Sharp with movement
- Stabbing
- Shooting
- Intense
- Burning
- Constricting
- Other: _____

Radiating: Does your pain seem to radiate from the primary area: Yes No If Yes, where does the pain radiate to?

Numbness/Tingling (pins and needles): Do you experience or have you recently experienced numbness and or tingling anywhere?

- None (no numbness or tingling)
- Yes: Please describe where and when you feel these symptoms: _____

Is your pain/discomfort WORSE:

- In the morning
- In the afternoon
- In the evening
- While sleeping
- While awake
- It does not seem to be affected by the time of day

Is your pain/discomfort BETTER:

- In the morning
- In the afternoon
- In the evening
- While sleeping
- While awake
- It does not seem to be affected by the time of day

Date: _____

Previous Surgeries (all types):

Approximate Date:

- 1. _____
- 2. _____
- 3. _____

Medical Doctors consulted in the past year:

Name: _____

Name: _____

Date of last visit: _____ Is this your primary care provider?

Date of last visit: _____ Is this your primary care provider?

Chiropractic Doctors consulted in the past year:

Name: _____

Name: _____

Approximate Date of last visit: _____

Approximate Date of last visit: _____

Please circle the following conditions you may have had in the past or have now:

- | | | | | |
|----------------------|----------------------|---------------------|--------------------|----------------------|
| Alcoholism | Convulsions | Gout | Migraine | Rubella |
| Allergies | Depression | Headaches | Miscarriage | Scoliosis |
| Anemia | Diabetes | Heart Attack | Multiple Sclerosis | Sinus Trouble |
| Arthritis | Diarrhea | Heart Disease | Mumps | Stroke |
| Back Pain | Ear Infections | High Blood Pressure | Neck Pain | Thyroid Problems |
| Bladder Infections | Eczema | Irregular Periods | Nervousness | Tuberculosis |
| Blood Vessel Disease | Epilepsy | Kidney Disease | Neuritis | Ulcers |
| Cancer | Fainting | Low Blood Sugar | Pleurisy | Uterine Cysts/Tumors |
| Chicken Pox | Flat Feet | Malaria | Pneumonia | Venereal Disease |
| Cold Sores | Gall Bladder Disease | Measles | Polio | Whooping Cough |
| Constipation | Glaucoma | Menstrual Cramps | Roseola | Other _____ |

Family History	Present Age	Age at Death	Medical Problems / Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____

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: _____