

(Please print)

PATIENT INFORMATION:

Date: _____

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

Preferred Name: _____ Home Phone _____ Cell Phone _____

Address: _____ City _____ State _____ Zip _____

Email address: _____

Height _____ Weight _____ Age _____ Date of Birth _____ Social Security # _____

Are you: A Minor _____ Married _____ Divorced _____ Widowed _____ Single _____ Sex: M / F

Employer: _____ Occupation _____

Work Phone: _____ E-Mail Address: _____

Spouse or Parent's Name: _____

Whom may we thank for referring you to us? _____

SYMPTOMS:

What were you doing when you first notice the pain? _____

Is this condition getting progressively worse or better? _____

Where specifically is the problem located? _____

Which activities are difficult to perform? _____ Sitting _____ Standing _____ Walking _____ Lying Down

Type of Pain: _____ Sharp _____ Dull _____ Throbbing _____ Numbness _____ Aching _____ Burning

Rate of severity of your pain, (1 is mild, 10 is severe) Please Circle: 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

Have you received other treatment for your condition? _____

If yes, please specify: _____ Medication _____ Surgery _____ Physical Therapy

_____ Other: _____

HEALTH HISTORY:(please mark any health problems you had/have in the past/present)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Pnuemonia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Rheumatiod Arthritis |
| <input type="checkbox"/> Prostrate Problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | <input type="checkbox"/> Herniated Disc | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Depression | _____ |

(Women Only)

Are you pregnant? Yes / No Nursing? Yes / No

Taking birth control pills? Yes / No

(OVER PLEASE)

HEALTH HISTORY CONT'D

What is the name of your current medical doctor? _____

List and types of surgeries you had had and the dates which they occurred: _____

Please list all medications you are taking: _____

Have you ever been to a chiropractor before? If so, whom? _____

Do you experience any foot pain? ____ Yes ____ No

Have you ever been in an auto accident? If so, what was the date? _____

Have you ever had spinal x-rays taken? If so, what was the date? _____

Do you have jaw pain or problems? _____

Do you have a family history of spinal problems? _____

DAILY HABITS

How do you sleep? Back ____ Side ____ Stomach ____

What do your daily work habits include? (Ex. Sitting, light labor, heavy labor, computer work, etc.)

What vitamins and/or other nutritional supplements do you take (if any)? _____

Do you smoke? ____ Yes ____ No

How many alcoholic drinks do you consume on a weekly basis (if any) ? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

How much water do you drink daily? _____

Are you using ice packs or heat or neither? _____

Are you covered by **MEDICARE** or **MEDICAID**? ____ No ____ Yes (*please present Card*)

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above Questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's or my health. I authorize the chiropractor to release any information including the dianosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners.

Patient Signature (if under 18 - parent / guradian)

Date

Printed Name