Please print legibly

PATIENT DATA

Name _____ Date _____ Referral _____

Address _____ City _____ State ____ Zip Code _____

Home Phone _____ Work Phone _____ Alternate Phone _____

E-mail _____

Social Security # _____ Driver's License # _____

Age _____ Birth date ____/____/____ Sex M / F Marital Status M S W D # of Children _____

Occupation _____ Employer _____ Years Employed _____

Spouse's Name _____ Occupation _____ Employer _____

Social Security # _____

Person responsible for this Account _____ Health Plan _____

Subscriber's Name _____ ID # _____ Group # _____

REASON FOR THIS VISIT

Please describe the reason for visit. This information is necessary to assist the doctor in understanding your condition.

Date condition began ____/____/____

_____

How bad is your pain? (Circle a number) 0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your **current** symptom

☐ Sharp/Stabbing ☐ Throbbing ☐ Aches
☐ Dull ☐ Soreness ☐ Weakness
☐ Numbness ☐ Shooting ☐ Gripping
☐ Burning ☐ Tingling ☐ Other

Since it began, is your condition: ☐ Improving ☐ Getting Worse ☐ No Change

What makes the condition better?

☐ Nothing ☐ Lying Down ☐ Walking
☐ Standing ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Other _____

What makes the condition worse?

☐ Nothing ☐ Lying Down ☐ Walking
☐ Standing ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Other _____

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

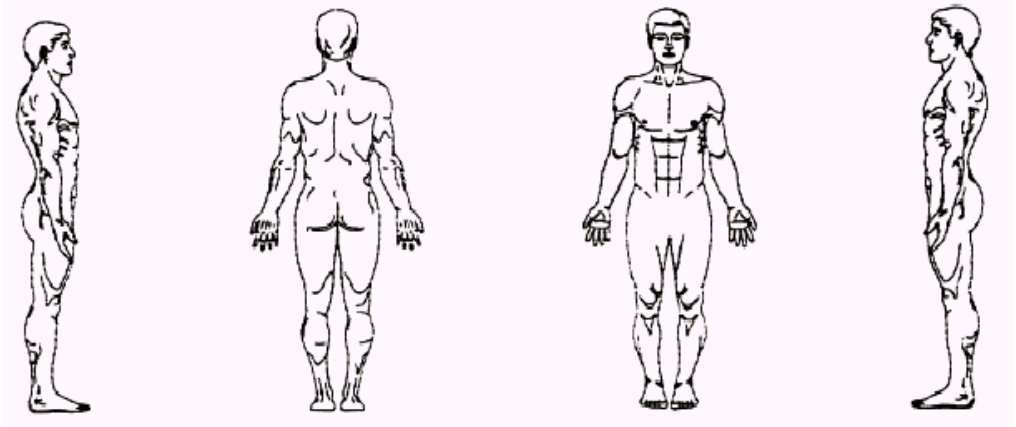
_____

_____

Have you had X-rays, MRI or other tests for this condition? What test and when? _____

_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING.



Patient Signature: _____ Date: _____

HEALTH CONDITIONS

If you are presently troubled by a particular symptom, please check that symptom. Knowledge of these conditions may influence the type of treatment you receive.

- ☐ Neck Pain
- ☐ Shoulder Pain (Right/Left)
- ☐ Pain in Upper Arm or Elbow (Right/Left)
- ☐ Hand Pain (Right/Left)
- ☐ Wrist Pain (Right/Left)
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Pain in Upper Leg or Hip (Right/Left)
- ☐ Pain in Lower Leg or Knee (Right/Left)
- ☐ Pain in Ankle or Foot (Right/Left)
- ☐ Jaw Pain
- ☐ Swelling, Stiffness of Joints
- ☐ Fainting
- ☐ Visual Disturbances
- ☐ Convulsions
- ☐ Dizziness
- ☐ Headache
- ☐ Muscular In coordination
- ☐ Tinnitus (ear noises)
- ☐ Rapid Heart Beat
- ☐ Chest Pains
- ☐ Loss of Appetite
- ☐ Anorexia
- ☐ Abnormal Weight (Gain/Loss)
- ☐ Excessive Thirst
- ☐ Chronic Cough
- ☐ Chronic Sinusitis
- ☐ General Fatigue
- ☐ Irregular Menstrual Flow
- ☐ Profuse Menstrual Flow
- ☐ Breast (Soreness/Lumps)
- ☐ Endometriosis
- ☐ PMS
- ☐ Loss of Bladder Control
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Abdominal Pain
- ☐ Constipation/irregular bowel habits
- ☐ Difficulty in Swallowing
- ☐ Heartburn/Indigestion
- ☐ Dermatitis/Eczema/Rash
- ☐ Depression
- ☐ Aortic Aneurysm
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Heart Attack (date)_____
- ☐ Stroke (date)_____
- ☐ Asthma
- ☐ Cancer (explain)_____
- ☐ Tumor (explain)_____
- ☐ Prostrate Problems
- ☐ Blood Disorder
- ☐ Emphysema (chronic lung disorders)
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Ulcers
- ☐ Liver/Gallbladder problems
- ☐ Kidney Stones
- ☐ Hepatitis
- ☐ Bladder Infection
- ☐ Kidney Disorder (by condition)
- ☐ Colitis
- ☐ Irritable Colon
- ☐ HIV/AIDS
- ☐ Other_____

Any Surgeries (Tonsils, etc.) _____

Please list any medications or vitamins that you currently take:

_____

_____

Present Weight _____ lbs

Height _____ feet _____ inches

Do you have a permanent disability rating? ☐ Yes ☐ No

Date rating received?_____/_____/_____

Rating Percentage _____ %

FOR WOMEN:

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you using birth control?	☐ Yes	☐ No
Method _____		
Do you experience painful periods?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No
Do you have breast implants?	☐ Yes	☐ No
Any other cosmetic surgeries?	☐ Yes	☐ No

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient's signature: Date:

Please print legibly

PATIENT DATA

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care-** Symptomatic relief of pain or discomfort

☐ **Corrective Care-** Correcting and relieving the cause of the problem as well as the symptoms

☐ **Comprehensive Care-** Bring whatever is malfunctioning in the body to the highest state of health with Chiropractic care

☐ **I want the Doctor to select the type of care appropriate for my condition**

EXPERIENCE WITH CHIROPRACTIC

Have you ever been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits?_____

Doctor's Name _____

Approximate Date of Last Visit _____

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No

the nervous system controls all bodily functions and systems? ☐ Yes ☐ No

Chiropractic is the largest natural healing profession in the world? ☐ Yes ☐ No

if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ☐ Yes ☐ No