

Confidential Patient Information

Name: _____ DOB: _____ Age: _____

Social Security Number: _____ - _____ - _____ (only disclose if you are comfortable or if it is required by your insurance company.)

Address: _____

City/State/Zip: _____

Home phone: _____ Cell: _____ Cell Ph. Co.: _____ Work: _____

Emergency Contact (name and phone #): _____ Relationship: _____

Email address: _____

How can we help you today?

- Chiropractic Care Nutritional Counseling Exercise Advise Lifestyle changes

Whom may we thank for referring you? _____

Are you in for a: Wellness/Health check-up or a Specific complaint

Is this condition affecting your everyday life? Yes No

Is it interfering with: Work Home life My hobbies My relationships My sleep My happiness My quality of life My Exercise Routine Everything!

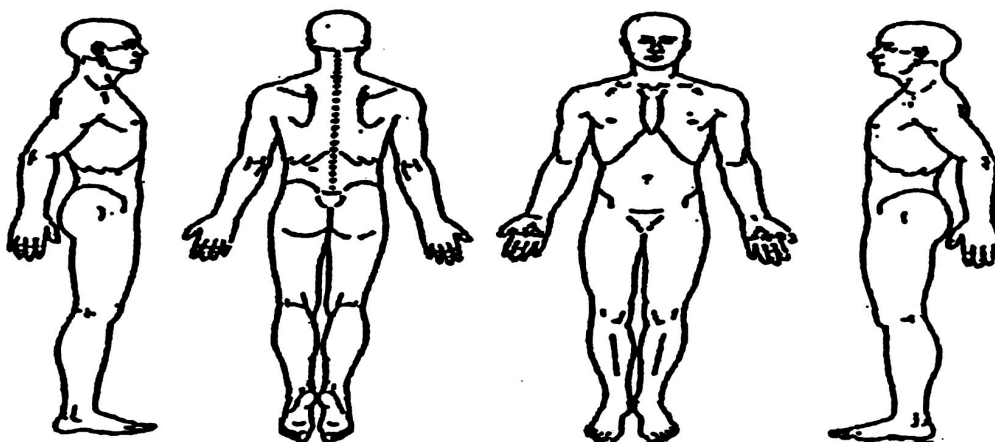
Have you seen a Chiropractor before? No Yes - Who? _____

When was the last time you were adjusted? _____

Did you have a good experience? Yes No; Anything you liked or disliked? _____

Who is your General Practitioner/ Family Physician? _____

If you are experiencing symptoms please indicate on the drawings below where you have pain/symptoms:



On a scale from 0-10 (10 being the worst), how would you rate your pain/symptoms?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

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How often do you experience your symptoms?

- Constantly (76-100% of the Time) Occasionally (26-50% of the Time)
 Frequently (51-75% of the Time) Intermittently (1-25% of the Time)

How would you describe your symptoms?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric-like with motion
 Stiff Other: _____

How long have you had this problem? _____

How do you think your problem began? _____

What aggravates your problem? _____

What alleviates your problem? _____

How are your symptoms changing with time?

- Getting worse Staying the same Getting better

What is your: Height _____ Weight _____ Occupation _____

What activities do you do at work? _____

How would you rate your overall health?

- Excellent Very Good Good Fair Poor

Rate your level of exercise activity:

- Strenuous Moderate Light None

Please describe your typical exercise routine: _____

Indicate if you suffer from, or have immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus Multiple Sclerosis
 Heart Problems Cancer ALS Parkinson's
 Any other diseases not asked: _____

Do you smoke? No Yes - how many per day? _____

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes -how much per day? _____

Please list all prescription and over-the-counter medications you are currently taking:

Please list all nutritional supplements you are currently taking:

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For the conditions listed below, please check the "past" column if you have had the condition in the past; If you presently have a condition listed below, please check the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness (with, w/o motion)		

Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy
- Abnormal menstrual cycle

Please list all surgical procedures you have undergone:

Have you ever been hospitalized? Yes No

If yes, why? _____

Have you had significant past trauma including, but not limited to, car accidents? Yes No

If yes, what and when? _____

What activities/hobbies do you enjoy outside of work?

Is there anything else you wish to let the doctor know about your visit today? Yes No

If yes, what? _____

Patient Signature _____ **Date** _____

Thank you for taking time to answer these questions as completely as possible, it will help us determine the best treatment plan for your individual needs.