motion CHIROPRACTIC
Improve Function, Improve Life.

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? _____

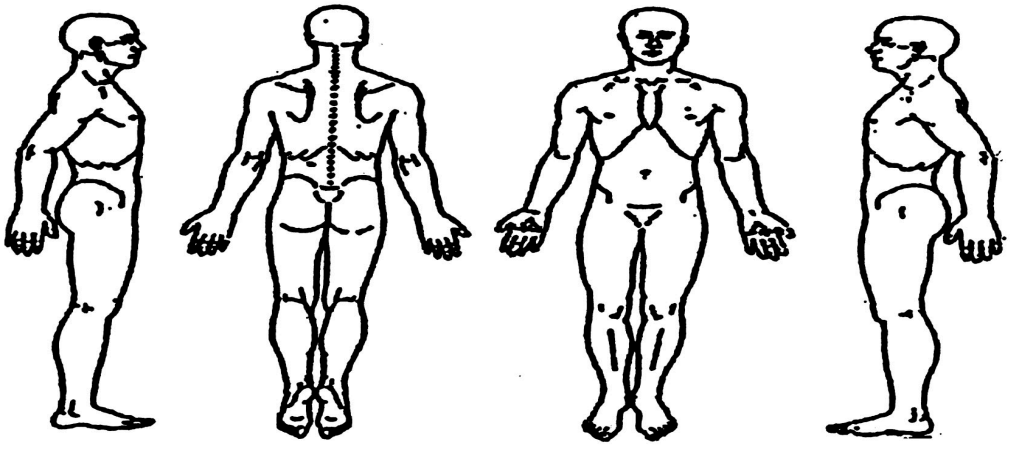
Are you in for a: ☐ **Wellness/Health check-up** or a ☐ **Specific complaint**

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

How would you describe your symptoms?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric-like with motion
□ 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
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Abnormal menstrual cycle
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness (with, w/o motion)		

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.