

Patient Data**Date:** _____**Title:** Mr. Mrs. Ms Miss (check one)**First Name:** _____ **Middle Initial:** _____ **Last Name:** _____**Address Line 1:** _____**Address Line 2:** _____**City:** _____ **State:** _____ **Zip Code:** _____**Home Phone:** (_____) _____ - _____ **Work Phone:** (_____) _____ - _____**Cell Phone:** (_____) _____ - _____**Date of Birth:** ____/____/____ **Sex:** Male Female **Email:** _____**Social Security Number:** _____ - _____ - _____ **Marital Status:** Single Married Other**Employment Status:** Employed Full Time Student Part Time Student Other (check one)**Spouse Data****Is your spouse a patient in the clinic?** Yes No**First Name:** _____ **Middle Initial:** _____ **Last Name:** _____**Home Phone:** (_____) _____ - _____ **Work Phone:** (_____) _____ - _____**Employer Data****Name:** _____**Address Line 1:** _____**Address Line 2:** _____**City:** _____ **State:** _____ **Zip Code:** _____**Emergency Contact****Contact Name:** _____**Contact Phone:** (_____) _____ - _____

Is it okay to call you at work?

- Yes No

How did you hear about our clinic? Or who referred you?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other |

If you selected 'Yellow Pages' please indicate which Yellow Pages:

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Medical Conditions:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |

Surgeries:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Radical prostatectomy | <input type="checkbox"/> Transurethral prostate surgery |

Allergies:

- | | | | |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seat belts never | <input type="checkbox"/> Wear seatbelts usually |

Family History:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | | |

Substance Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (Present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | | |

Male Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Female Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Occupational Activities:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

No _____

- Poor Circulation
- High Blood Pressure
- Aortic Aneurism
- Heart Disease
- Heart Attack
- Chest Pain
- High Cholesterol
- Pace Maker
- Jaw Pain
- Irregular Heartbeat
- Swelling of Legs

	Present	Past	No

Genitourinary:

No _____

- Kidney Disease
- Lower Side Pain
- Burning Urination
- Frequent Urination
- Kidney Stone

	Present	Past	No

Hematologic/lymphatic:

No _____

- Hepatitis
- Blood Clots
- Cancer
- Easy Bruising
- Easy Bleeding
- Fever/Chills/Sweats

	Present	Past	No

Neurologic:

No _____

- Stroke
- Seizures
- Head Injury
- Brain Aneurysm
- Numbness
- Severe Headaches
- Pinched Nerves
- Parkinson's Disease
- Carpal Tunnel
- Spinning/Balance

	Present	Past	No

Respiratory:

No _____

- Asthma
- Tuberculosis
- Shortness of Breath
- Emphysema
- Cold/Flu
- Cough/Wheezing

	Present	Past	No

Ears/Nose/Throat:

No _____

- Dizziness
- Hearing Loss
- Sinus Infection
- Nosebleed
- Sore Throat
- Difficulty Swallowing
- Bleeding Gums

	Present	Past	No

Eyes:

No _____

- Glaucoma
- Double Vision
- Blurred Vision

	Present	Past	No

Integumentary:

No _____

- Skin Ulcers
- Skin Disease
- Eczema
- Psoriasis
- Rashes

	Present	Past	No

Psychiatric:

No _____

- Depression
- Anxiety Disorder
- Unusual Stress

	Present	Past	No

Constitutional:

No _____

- Weight Loss/Gain
- Energy Level Problem
- Difficulty Sleeping

	Present	Past	No

Allergic/Immunologic:

No _____

- Hives
- Immune Disorder
- HIV/AIDS
- Allergy Shots
- Cortisone Use

	Present	Past	No

Gastrointestinal:

No _____

- Gallbladder Problems
- Bowel Problems
- Constipation
- Liver Problems
- Ulcers
- Diarrhea
- Nausea/Vomiting
- Bloody Stools
- Poor Appetite

	Present	Past	No

Musculoskeletal:

No _____

- Gout
- Arthritis
- Joint Stiffness
- Muscle Weakness
- Osteoporosis
- Broken Bones
- Joints Replaced

	Present	Past	No

Endocrine:

No _____

- Thyroid Disease
- Diabetes
- Hair Loss
- Menopausal
- Menstrual Problems

	Present	Past	No

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

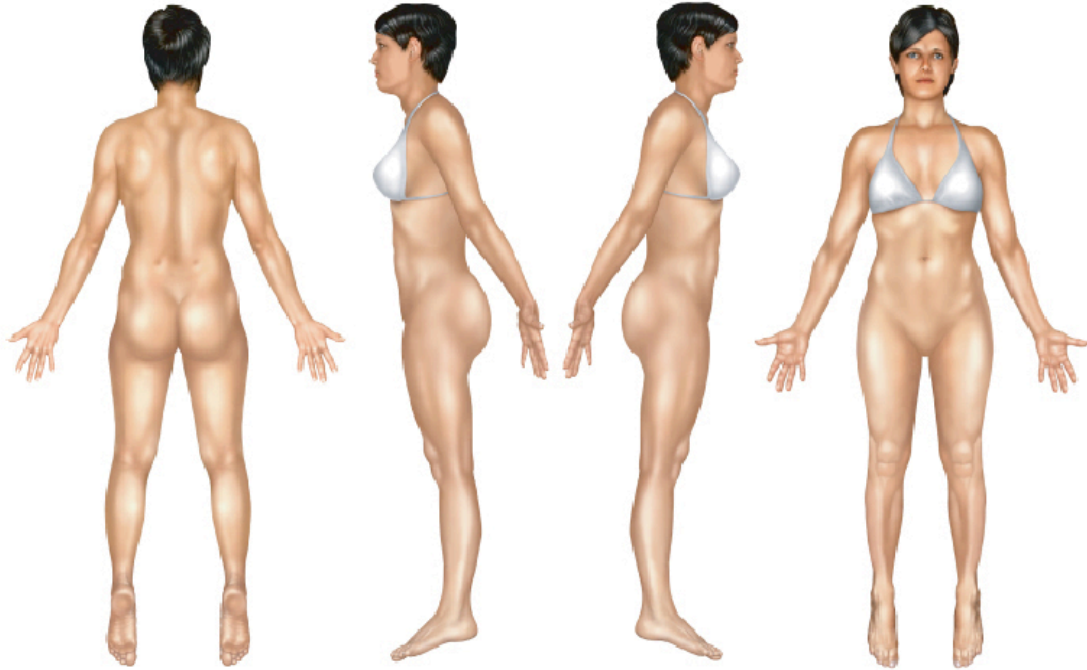
= Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling
- Stabbing

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- 0 None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

In general, would you say your overall health right now is....

- Excellent Very good Good Fair
 Poor

Who have you seen for your symptoms:

- No one Other Chiropractor Medical Doctor Physical Therapist
 Other

What treatment did you receive for your symptoms?

- Adjustments Physical Therapy Medication Surgery
 Other

When did you receive this treatment?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 – 2 years ago 2 – 5 years ago 5 – 10 years ago

What tests have you had for your symptoms?

- X-rays MRI CT Scan Other

When were these tests done?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 - 2 years ago 2 – 5 years ago 5 – 10 years ago

Have you had similar symptoms in the past?

- Yes No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- This Office Other Chiropractor Medical Doctor Physical Therapist
 Other

What is your occupation?

- Professional/Executive White Collar/Secretarial Tradesperson Laborer
 Homemaker Full-time Student Retired Other

If you are not retired, a homemaker or a student, what is your work status?

- Full-time Part-time Self-employed Unemployed
 Off work Other

Thank you. Please return to the front desk.