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?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ 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:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transurethral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionall	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ Heart problems (sibling)	❑ High blood pressure (parent)	❑ High blood pressure (sibling)
❑ Psychiatric (parent)	❑ Psychiatric (sibling)	❑ Stroke (parent)	❑ Stroke (sibling)
❑ Thyroid (parent)	❑ Thyroid (sibling)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)
❑ Crystal Meth (past)	❑ Crystal Meth (present)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)		

Male Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Female Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Occupational Activities:

❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Heavy manual labor	❑ Home services
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular: No ______

	Present	Past	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			

Genitourinary: No ______

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Kidney Stone			

Hematologic/lymphatic: No ______

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fever/Chills/Sweats			

Neurologic: No ______

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory: No ______

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No ______

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes: No ______

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No ______

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric: No ______

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional: No ______

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic: No ______

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal: No ______

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No ______

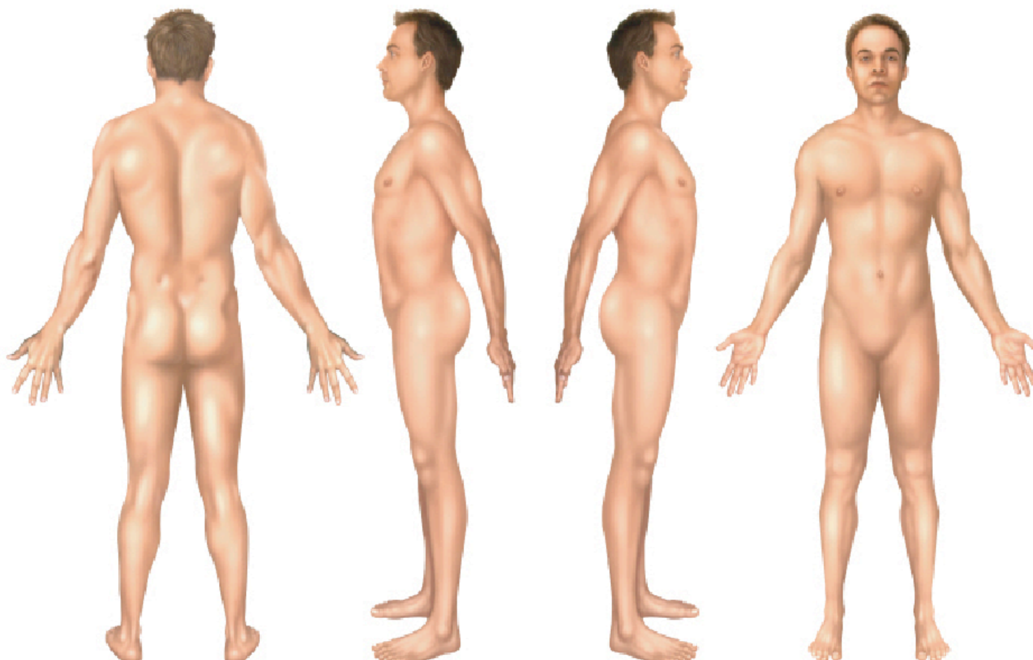
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine: No ______

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

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.