Patient Information

Name _____ Birth date _____ Age _____ Sex [M F]

First Middle Last

Address_____ Home Phone _____ Work Phone_____

City _____State_____Zip_____ Cell Phone_____ Ok to text appointments? Y / N

Insurance Company _____ Social Security # _____

Marital Status M W D S Spouse's Name_____ Employer Name _____

Children's Names _____ Occupation _____

What is your current problem/complaint? _____

Is this condition due to: [ ] Auto accident [ ] Work injury [ ] Other accident [ ] Illness [ ] Unknown cause

Date symptoms appeared _____ **If Accident, please describe what happened**: _____

_____

What aggravates your condition: [ ] Standing [ ] Twisting [ ] Bending [ ] Sitting [ ] Lying [ ] Walking [ ] Coughing [ ] Lifting

What is your average pain rating over the past 2 weeks? (0-10) _____ (0 = no pain, 10 = max pain)

Are your symptoms:
[ ] Improving
[ ] About the same
[ ] Getting Worse
[ ] Intermittent (come and go)

List all <u>prescription</u> drugs you now take:
_____
_____
_____
_____
_____

List all <u>non-prescription</u> drugs you now take:
_____
_____
_____
_____
_____

Have you had these symptoms before?
[ ] NO
[ ] YES When? _____

List all surgical operations:
_____
_____
_____
_____
_____

Check here if you have a history of:
[ ] diabetes
[ ] stroke
[ ] cancer
[ ] cardiovascular disease

Who is your family doctor?
Dr. _____

Social Habits: [ ] tobacco [ ] alcohol [ ] coffee
Body Weight [ ] average [ ] overweight [ ] obese

Have you had a history of chronic pain for more than 6 months? [ ] yes [ ] no
Do you currently suffer from depression or anxiety issues? [ ] yes [ ] no
Have you seen a chiropractor before? If so, when? _____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU MAY HAVE HAD:

[ ] High Blood Pressure	[ ] Asthma	[ ] Gastric Ulcers	[ ] Joint Pains
[ ] Heart Disease	[ ] Bronchitis	[ ] Colitis/Spastic Colon	[ ] Jaw Pain
[ ] Heart Murmurs	[ ] Pulmonary Disease	[ ] Acid Reflux	[ ] Shoulder Pain
[ ] Diabetes	[ ] Emphysema	[ ] Hiatal Hernia	[ ] Numbness
[ ] Headaches	[ ] Pneumonia	[ ] Gas/Bloating	[ ] Hepatitis A B C
[ ] Sinus/Allergies	[ ] Kidney Stones	[ ] Premenstrual Pains	[ ] HIV+ / AIDS

Who referred you to our office?

_____

The above information is true and accurate to the best of my knowledge

Signature: _____Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____