# 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:_____ /_____