

Patient Demographic Information



Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Number: _____ Other Number: _____

Occupation: _____ Employer: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Gender M F E-mail: _____

Single Divorced Married Widowed

Number of Children and Ages: _____

Spouse's Name: _____ Employer: _____

Emergency Contact: _____

Have you received chiropractic care in the past? Yes No If yes, please give the date and name of the chiropractor, as well as the reason for previous care: _____

Name of your Medical Doctor: _____

Name of your health insurance company: _____

Complete if applicable to your current health condition:
 Personal Injury Auto Accident Workers Compensation

Insurance Policy #: _____

If you have consulted an attorney, regarding the above, please provide their name, address and phone number:

Patient Condition

Reason(s) for visit:

Is this condition due to an accident? Yes No Auto Work Home Other Date:_____

When did your symptoms appear?_____ Is this condition getting worse?_____

How often do you have this problem?_____ Is it constant or does it come and go?_____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities/movements that are difficult/painful to perform: Sitting Standing Walking Bending Lying Down

Mark an "X" on the picture where you continue to have pain, numbness or tingling

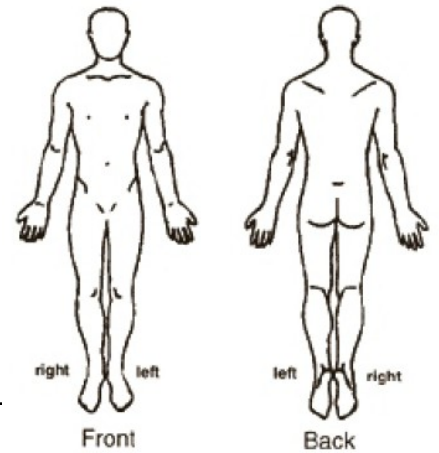
On a scale from 0 to 10, 0 being no pain, 10 being extreme what is it:

At Rest?_____

With Activity?_____

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Care None



Medications

- Blood Pressure
- Birth Control
- Muscle Relaxant
- Antidepressant
- Pain Medication
- Cholesterol Medication
- Diabetic Medication
- Steroids
- Antibiotics
- Antianxiety
- Heart Medication
- Thyroid Medication

Allergies

- Pollen
- Dust
- Ragweed
- Latex
- Animals
- Other:_____

Vitamins/Herbs Minerals/Supplements

- _____
- _____
- _____
- _____
- _____
- _____



Personal Health History: Please indicate whether you have/had any of the following

Are you currently under the care of a healthcare provider or any other doctor? Yes No

If yes, for what condition(s) _____

Provider's Name: _____ Phone: _____

Name of Previous Chiropractor: _____

Date of Last: Chiropractic Exam: _____ Spinal X-Ray: _____ Cholesterol: _____

Prostate/PSA: _____ Mammogram: _____ Pap Smear: _____ Stool check for blood: _____

Colon: _____ MRI: _____ CT-Scan: _____

Place mark if you have any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Liver Trouble/Hepatitis | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shoulder/Arm Problems | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Unexplained Fatigue |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Jaw Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Throat Problems | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Chronic Cough/Cold |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Mid Back/Rib Pain | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Diabetes Type I or II |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hypertension/High Blood Pressure |
| <input type="checkbox"/> Wrist/Elbow/Hand Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Hip/leg Problems | | |

Other, please specify: _____

Are you pregnant? Yes No Due Date: _____

Are any of the following? (include number) Pregnancies: _____ Live Births: _____ Miscarriages: _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Have you ever:	Description	Date
Lost Consciousness	-----	-----
Used a Cane/Crutch	-----	-----
Had Mental/Emotional Disorders	-----	-----
Been Treated for Spine/Nerve Disorder	-----	-----

Family History				
Relation	Living	Deceased	Age (now or at death)	Serious Illness/Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

Social History	
WORK ACTIVITY:	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor What job did you do during most of your life? _____
DIET/NUTRITION:	Are you on any special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason? _____ Is your weight a concern for you emotionally or physically? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you gained or lost over 10 pounds in the past six months without wanting to? <input type="checkbox"/> Yes <input type="checkbox"/> No My diet emphasizes fruits, vegetables, whole grains. Lean meats or other protein sources, and is low in saturated fats, sugars and salt. Rate your diet on a scale of 0 to 10: <div style="text-align: right;"> <input type="checkbox"/>0 <input type="checkbox"/>1 <input type="checkbox"/>2 <input type="checkbox"/>3 <input type="checkbox"/>4 <input type="checkbox"/>5 <input type="checkbox"/>6 <input type="checkbox"/>7 <input type="checkbox"/>8 <input type="checkbox"/>9 <input type="checkbox"/>10 </div> How many eight ounce glasses of water do you drink daily? _____ How many caffeine drinks do you drink a day?(soda, coffee, etc.) Cans____ Cups____ None____
HABITS:	Tobacco Use: Now? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount/Weekly___ How long? ___Years/Months (Smoking/Smokeless) In the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount/Weekly___ How long? ___Years/Months Alcohol Use: Now? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount/Weekly___ How long?___ Years/Months In the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount/Weekly___ How long?___ Years/Months
Do you have any concerns about your sexual health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you or have you ever been a victim of domestic or sexual abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No