Patient Information

Date:

Title: ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss (check one) **Sex:** ☐ Male ☐ Female (check one)

First Name_____ **Middle Initial**_____ **Last Name**_____

Current Address_____**City**_____**State**_____**Zip Code**_____

Permanent Address (if different from above)_____

Home Phone (_____)_____-_____ **Work Phone** (_____)_____-_____

Cell Phone (_____)_____-_____ **Email** _____

Date of Birth _____/_____/_____ **Age**_____

Social Security Number _____-_____-_____ **Marital Status** ☐ Single ☐ Married ☐Other

Family Information

Spouse Name _____ **Children (**Name / Age)_____

Spouse's Occupation_____

Occupation Information

Employment Status ☐ Employed (circle: full / part) ☐ Student (circle: full / part) ☐ Other_____

Occupation_____

Employer Name _____

Address_____**City** _____**State** _____ **Zip Code:** _____

Emergency Contact

Contact Name_____ **Relationship**_____

Contact Phone: (_____) _____-_____

How did you hear about our clinic? ☐ Newspaper ☐ Yellow Pages ☐ Website ☐ Health Class ☐ Other_____

Referred By (circle: Physician / Family / Friend / Employer / Attorney) **Name**_____

History of Illness/Injury/Pain

Chief Complaint and its location_____

_____

How did your symptoms begin?_____

_____

When did your symptoms start? Month_____ **Day**_____ **Year**_____

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, please rate the following:

Today my pain is at:

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

What is the least intense the symptoms have been:

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

What is the most intense the symptoms have been:

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

How are your symptoms changing?

☐ Getting better ☐ Getting Worse ☐ About the same

How would you best describe the sensation of your pain/symptoms? (check all that apply)

☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Burning ☐ Stinging ☐ Throbbing
☐ Tingling ☐ Pounding ☐ Numb ☐ Crawling ☐ Prickly ☐ Pulsating ☐ Pin & Needles
☐ Deadness ☐ Hurting ☐ Soreness ☐ Excruciating

How often do you experience your symptoms?

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

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/leisure activities?

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

What makes the pain/symptoms worse? (check all that apply)

☐ Coughing ☐ Sneezing ☐ Lifting ☐ Carrying ☐ Sitting ☐ Standing ☐ In/Out of Bed
☐ Walking ☐ Running ☐ Exercising ☐ Driving ☐ Pulling ☐ Pushing ☐ Looking Up/Down
☐ Stress ☐ Up Stairs ☐ Down Stairs ☐ General Movement ☐ Looking Side/Side
☐ Other_____

What makes the pain/symptoms better? (check all that apply)

☐ Resting ☐ Sleeping ☐ Sitting ☐ Standing ☐ Walking ☐ Exercise ☐ Heat ☐ Ice
☐ Medication ☐ Tylenol ☐ Advil/Aleve ☐ Other_____

Have you seen anyone for this condition? ☐ No ☐ Yes

Name:_____

(Circle: Chiropractor, Medical Doctor, Physical Therapist, Other)

What treatments/tests have you received/performed for your symptoms?

☐ Adjustments ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Heat ☐ Ice ☐ Supplements
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other_____

When did you receive this treatment?

☐ Within 1 month ☐ 2–3 months ago ☐ 3–6 months ago ☐ 6 months - 1 year ago
☐ 1–2 years ago ☐ 2–5 years ago ☐ 5–10 years ago

Have you had similar symptoms in the past? ☐ No ☐ Yes (if yes, who was seen for this condition)

(Circle: This office, Other Chiropractor, Medical Doctor
Physical Therapist, Other_____

Current Health

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Frequency of Exercise… ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

Intensity of Exercise… ☐ Low ☐ Moderate ☐ High ☐ Competition

Average Hours of Sleep_____ **Do you feel well rested after sleep?** ☐ No ☐ Yes ☐ Sometimes

Caffeine Use… ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently **Daily Amount**_____

Alcohol Use… ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently **Drinks/Week**_____

Tobacco Use… ☐ No ☐ Yes **Type**_____ **Daily Quantity**_____

Recreational Drug Use… ☐ No ☐ Yes_____

Stress Level… ☐ Low ☐ Moderate ☐ High

Allergies: ☐ Eggs ☐ Fish/Shellfish ☐ Milk/Lactose ☐ Peanut ☐ Soy ☐ Sulfites ☐ Wheat/Gluten
☐ None ☐ Other _____

Recreational Activities/Hobbies_____

_____

Do you currently or have had in the past any of the following conditions:

Past Present	Past Present	Past Present	Past Present	Past Present
☐ ☐ Arthritis	☐ ☐ Joint Pain	☐ ☐ Neck Pain	☐ ☐ Mid Back Pain	☐ ☐ Low Back Pain
☐ ☐ Headaches	☐ ☐ Dizziness	☐ ☐ Sinus Problems	☐ ☐ Ear Infections	☐ ☐ Thyroid Problems
☐ ☐ Cancer	☐ ☐ Diabetes	☐ ☐ Fatigue/Tired	☐ ☐ Carpal Tunnel	☐ ☐ General Stiffness
☐ ☐ Asthma	☐ ☐ Depression	☐ ☐ Psychiatric Illness	☐ ☐ Skin Disorder	☐ ☐ Prostate Problems
☐ ☐ Diarrhea	☐ ☐ Constipation	☐ ☐ Ulcers/Colitis	☐ ☐ Arm/Leg Numbness	☐ ☐ Muscular Weakness
☐ ☐ Stroke	☐ ☐ Impotence	☐ ☐ High Cholesterol	☐ ☐ Heart Disease	☐ ☐ High Blood Pressure
☐ ☐ HIV/AIDS	☐ ☐ Hepatitis	☐ ☐ Frequent Colds	☐ ☐ Osteoporosis	☐ ☐ Other_____
Women Only:				
☐ ☐ Pregnancy	☐ ☐ PMS	☐ ☐ Painful Periods	☐ ☐ Birth Control	☐ ☐ Irregular Cycles

Please list all past Surgeries/Hospitalizations/Major Accidents_____

_____

Please list all Current Medications/Supplements_____

_____

Does anyone in your family currently have or has had any of the following conditions:

☐ Arthritis ☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke
☐ Cancer (Type:_____) ☐ Thyroid Problems ☐ Depression ☐ Other_____

Please let us know how we can best help you reach your goals:

☐ Pain/Symptom Relief ☐ Improve Structure and Function ☐ Improve Activity/Flexibility
☐ Optimal Health/Wellness ☐ All of the Above