

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
☐ Other _____		☐ Other _____	

Surgeries:

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical disc procedure	☐ Hysterectomy
☐ Joint replacement	☐ Laminectomies	☐ Radical prostatectomy	☐ Transurethral prostate surgery
☐ Other _____		☐ Other _____	

Allergies:

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanut
☐ Soy	☐ Sulfites	☐ Wheat/Gluten	☐ Other _____

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 occasionally	☐ 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)	☐ Other _____	

Substance Use:

☐ Alcohol (past)	☐ Alcohol (present)	☐ Amphetamines (past)	☐ Amphetamines (present)
☐ Barbiturates (past)	☐ Barbiturates (present)	☐ Cocaine (past)	☐ Cocaine (present)
☐ Crystal Meth (past)	☐ Crystal Meth (present)	☐ Heroin (past)	☐ Heroin (Present)
☐ Marijuana (past)	☐ Marijuana (present)	☐ Other _____	

Male Children:

☐ Under 6 years	☐ Under 10 years	☐ Under 19 years
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Female Children:

☐ Under 6 years	☐ Under 10 years	☐ Under 19 years
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Occupational Activities:

☐ Administration	☐ Business owner	☐ Clerical/secretarial	☐ Computer user
☐ Construction	☐ Daycare/childcare	☐ Executive/legal	☐ Food service industry
☐ Healthcare	☐ Heavy equipment operator	☐ Heavy manual labor	☐ Home services
☐ Household	☐ Light manual labor	☐ Manufacturing	☐ Medium manual labor
☐ Military	☐ Police/fire	☐ Professional Service	☐ Teacher

☐ Truck driver ☐ Other _____

Recreational Activities:

☐ Backpacking
☐ Golf
☐ Skiing
☐ Walking

☐ Biking
☐ Racket ball
☐ Soccer
☐ Weight lifting

☐ Boating
☐ Rock climbing
☐ Swimming
☐ Other _____

☐ Football
☐ Running
☐ Tennis

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

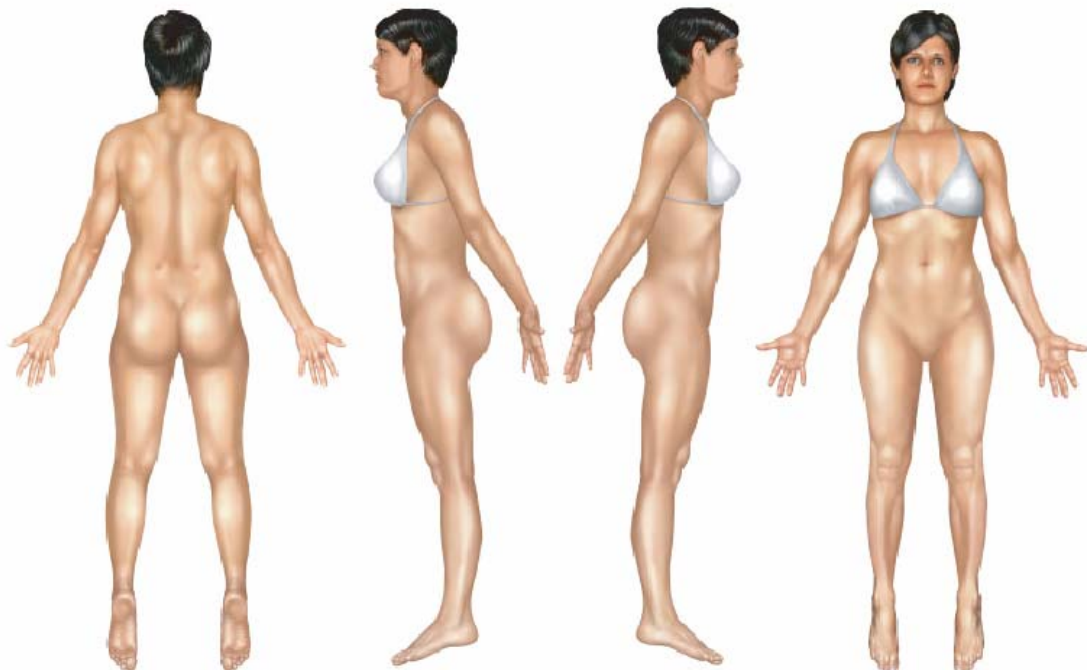
= Numbness

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
☐ Burning ☐ Tingling

☐ Numb
☐ Stabbing

☐ Shooting

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.

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			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic:

No

Present

Past

No

Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/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			