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	❑ Transuretheral 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 occasionall	❑ 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)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)	❑ Other _____	

Male Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Female Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Occupational Activities:

❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Heavy manual labor	❑ Home services
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor

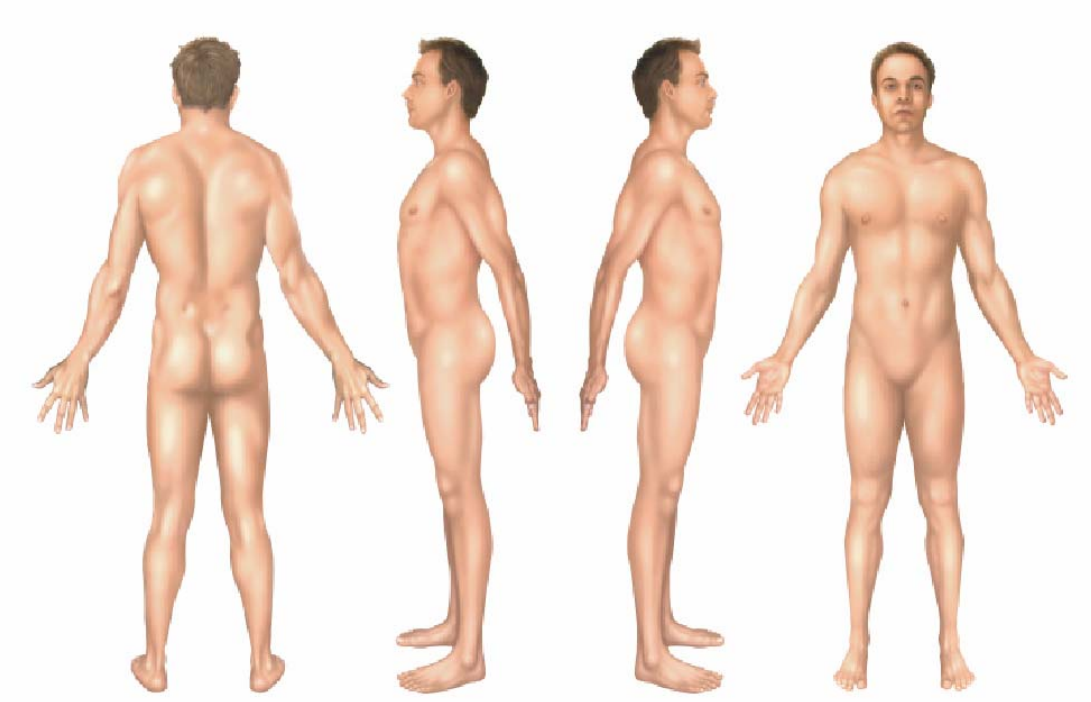
❑ Military ❑ Police/fire ❑ Professional Service ❑ Teacher
❑ Truck driver ❑ Other _____

Recreational Activities:

❑ Backpacking ❑ Biking ❑ Boating ❑ Football
❑ Golf ❑ Racket ball ❑ Rock climbing ❑ Running
❑ Skiing ❑ Soccer ❑ Swimming ❑ Tennis
❑ Walking ❑ Weight lifting Other _____

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 ❑ Numb ❑ Shooting
❑ Burning ❑ Tingling ❑ Stabbing

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			