PATIENT INFORMATION

Full Name: _____ Date _____/_____/_____

Address: _____City: _____State: _____Zip: _____

Sex: ☐ Male ☐ Female Age: ____ Date of Birth: _____/_____/_____ Social Security #: _____

Whom may we thank for referring you? _____

EMERGANCY CONTACT INFORMATION FOR PARENT/GAURDIAN

Parent/Guardian Full Name: _____

Address: _____City: _____State: _____Zip: _____

Home: _____ Cell: _____ Work: _____ Ext: _____ Text-Message Enabled? ☐ Yes ☐ No

What is the best time and place to reach you? _____ I would like to receive appointment

E-mail Address: _____ reminders via: **TEXT** or **EMAIL**

Cell Provider: _____

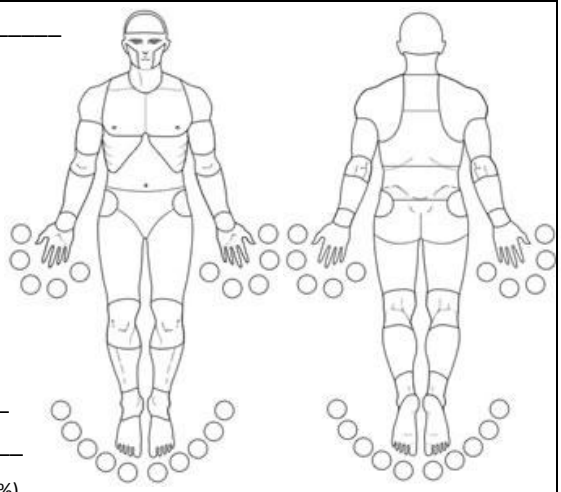
PATIENT CONDITION

Area of Primary Complaint: _____

When did the symptoms first appear? _____

How did the symptoms start? _____

_____



Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Not sure/no change

Pain Rating: (mark circles)

Currently:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
Average:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
At Best:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
At Worst:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain

Do the symptoms radiate to any other body parts? _____

Described as: ☐ Aching ☐ Burning ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Other: _____

Frequency: ☐ Infrequent (<25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (>75%)

These Symptoms have interfered with Activities of Daily Living: ☐ Extremely ☐ Quite a Bit ☐ Moderately ☐ A Little Bit ☐ Not at All

Time of day at worst: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night *and/or* **After Activity:** ☐ Normal ☐ Light ☐ Moderate ☐ Heavy

Does it interfere with: ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ House Work ☐ Other: _____

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other: _____

What makes it better? ☐Medication ☐ Lying Down ☐Standing ☐Sitting ☐Stretching ☐ Ice ☐ Heat ☐ Sleep ☐ Nothing ☐ Other: _____

What makes it worse?

□ Movements	□ Sneezing	□ Yawning	□ Running	
□ Bending	□ Sitting	□ Opening Mouth	□ Bright Lights	□ Laying Down
□ Twisting	□ Standing	□ Closing Mouth	□ Loud Noises	□ Other: _____
□ Weight Bearing	□ Walking	□ Range of Motion	□ Watching TV	□ Other: _____
□ Neck Flexion	□ Chewing	□ Pushing/Pulling		

Pregnancy/Birth History

(For children from **birth to 3 years**):

- **Was the pregnancy full-term?** ☐ Yes ☐ No, born at ____ weeks
- **Interventions or Complications:** ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum Extraction ☐Breach ☐Induction ☐Pain Medications ☐Epidural
- **Was the child breastfed or formula-fed?** ☐ Breast ☐ Formula; If formula, what kind? _____ If breast, how long? _____
- **Any difficulty with breastfeeding/latching?** ☐ Yes ☐ No
- **Childs weight and height at birth: Weight**_____ **Height**_____

HEALTH HISTORY

Present Illness/Conditions: (mark all that apply)

☐ Scoliosis	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Hip Dysplasia	☐ Ulcer
☐ ADHD	☐ Diabetes	☐ Dislocated Joints	☐ Pacemaker	☐ Thyroid Trouble	☐ Polio
☐ Allergies	☐ Diverticulitis	☐ Cirrhosis/Hepatitis	☐ Prostate Trouble	☐ Tuberculosis (TB)	☐ RSV
☐ Anemia	☐ Low Blood Pressure	☐ Kidney Trouble	☐ Rheumatic Fever	☐ Hay Fever	☐ AIDS
☐ Arthritis	☐ High Blood Pressure	☐ Mental Disorder	☐ Sinus Trouble	☐ Bone Fracture	☐ HIV/ARC
☐ Asthma	☐ Colic	☐ Constipation	☐ Digestive Issues	☐ Ear Infections	☐ GERD
☐ Autism	☐ Torticollis	☐ Strep Throat	☐ Bed Wetting	☐ Tongue-tied	

Family History of Illness/Conditions: (mark all that apply)

☐ Scoliosis	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Disc Disease	☐ Ulcer
☐ Allergies	☐ Diabetes	☐ Dislocated Joints	☐ Pacemaker	☐ Thyroid Trouble	☐ Polio
☐ Anemia	☐ Diverticulitis	☐ Cirrhosis/Hepatitis	☐ Prostate Trouble	☐ Tuberculosis (TB)	☐ STDs
☐ Arthritis	☐ Low Blood Pressure	☐ Kidney Trouble	☐ Rheumatic Fever	☐ Hay Fever	☐ AIDS
☐ Asthma	☐ High Blood Pressure	☐ Mental Disorder	☐ Sinus Trouble	☐ Bone Fracture	☐ HIV/ARC

Other:

Milestones Met: (Please check all that apply based on child's age)

Birth to 6 months:	**6 Months to 1 year:**	**1 to 3 Years:**
☐ Turns head to both sides	☐ Rolls over both directions	☐ Walks independently
☐ Lifts head during tummy time	☐ Sits without support	☐ Climbs and runs
☐ Pushes up on arms	☐ Crawls	☐ Uses simple words/phrases
☐ Follows objects with eyes	☐ Pulls up to stand	☐ Imitates actions
☐ Shows reaction to sounds	☐ Responds to name	☐ Shows preference for one hand

3 to 10 years:
☐ Jumps with both feet
☐ Balances on one foot
☐ Rides a bike (with or without training wheels)
☐ Speaks in full sentences
☐ Writes/draws with a pencil or crayon

Check any treatments tried in treating this condition: ☐ Ice ☐ Dry Heat ☐ Moist Heat ☐ Stretching ☐ Massage

☐ Physical Therapy ☐ Bed Rest ☐ Medications ☐ Other: _____

Results from treatments:

_____

List any medications he/she is currently taking:

_____

Sleeping Habits: Position: ☐ Back ☐ Stomach ☐ Left Side ☐ Right Side How many hours of sleep at night? _____

Bed Type: ☐ Crib ☐ Conventional ☐ Water ☐ Tempurpedic ☐ Air Pillows at head? ⓪ ① ② At Knees? ⓪ ① ② Body Pillow? ☐YES ☐NO