## PATIENT INFORMATION

Full Name: _____ Date _____/_____/_____

Address: _____City: _____State: _____Zip: _____

Sex: ☐ Male ☐ Female Age: ____ Date of Birth: _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Driver License #: _____
(HIPAA requires us to obtain a copy of your driver's license)

Occupation: _____ ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

Employer: _____ Length of Employment: _____

Spouse's Name: _____ Occupation: _____

Employer: _____ Length of Employment: _____

Number of Children & year of births: (women only)

_____

Whom may we thank for referring you? _____

## CONTACT INFORMATION

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**?

**IN CASE OF EMERGENCY, CONTACT:** **Cell Provider: _____**

Name: _____ Relationship: _____

Home: _____ Work: _____ Ext: _____ Cell: _____

## PATIENT CONDITION

Area of Primary Complaint: _____

When did your symptoms first appear? _____

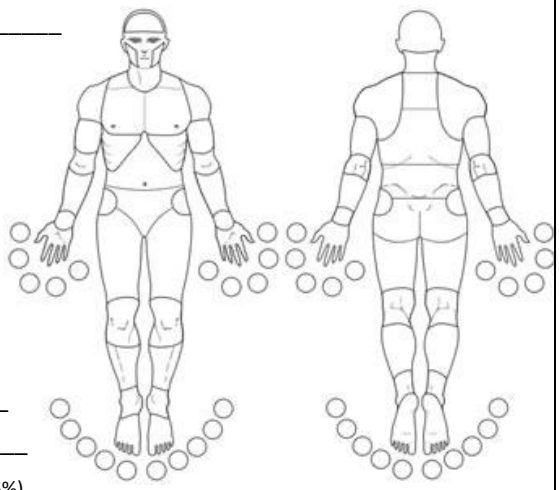
How did your symptoms start? _____

_____

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 my 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 your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ House Work ☐ Driving ☐ 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 | ☐ Lifting | ☐ Working |
| ☐ Bending | ☐ Sitting | ☐ Opening Mouth | ☐ Bright Lights | ☐ Driving |
| ☐ Twisting | ☐ Standing | ☐ Closing Mouth | ☐ Loud Noises | ☐ Housework |
| ☐ Weight Bearing | ☐ Walking | ☐ Range of Motion | ☐ Watching TV | ☐ Other: _____ |
| ☐ Neck Flexion | ☐ Chewing | ☐ Pushing/Pulling | ☐ Reading | ☐ Other: _____ |

Comments:

# HEALTH HISTORY

**Present 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:

**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:

| **Past Injuries/Surgeries:** | | **Description** | **Date** |
|---|---|---|---|
| Auto Accidents | ☐Yes ☐No | _____ | _____/_____/_____ |
| Slips/Falls | ☐Yes ☐No | _____ | _____/_____/_____ |
| Broken Bones | ☐Yes ☐No | _____ | _____/_____/_____ |
| Surgeries | ☐Yes ☐No | _____ | _____/_____/_____ |

Previous Chiropractic Physician/Location: _____ Last Seen: _____

Current Medical Physician/Location: _____ __ Last Seen: _____

Other medical providers consulted for this condition: _____

Facility and Date of last: X-RAY_____ _____/_____/_____

MRI _____ _____/_____/_____

CT/BONE SCAN _____ _____/_____/_____

Family History of back problems? ☐NO ☐YES, explain: _____

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

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

Results from treatments: _____

List any medications you are currently taking: _____

Sleeping Habits: Position: ☐ Back ☐ Stomach ☐ Left Side ☐ Right Side

Bed Type: ☐ Conventional ☐ Water ☐ Tempurpedic ☐ Air Pillows at head? ⓪ ① ② ③ At Knees? ⓪ ① ② ③ Body Pillow? ☐YES ☐NO

Activities you enjoy when healthy: ☐ Stretch ☐ Jog ☐ Walk ☐ Elliptical ☐ Weights ☐ Tennis ☐ Bowl ☐ Golf ☐ Other: _____

# SOCIAL HISTORY

| **EXERCISE** ☐YES ☐NO | **WORK ACTIVITY** | **HABITS** | |
|---|---|---|---|
| ☐ Light | ☐ Sitting ☐ Computer Work | ☐ Smoking | Packs/Day: _____ |
| ☐ Moderate | ☐ Standing | ☐ Alcohol | Drinks/Week: _____ |
| ☐ Heavy | ☐ Light Labor | ☐ Coffee/Caffeine Drinks | Drinks/Day: _____ |
| Hours/week: _____ | ☐ Heavy Labor | ☐ High Stress Level | Reason: _____ |

**WOMEN:** Date of last menses: _____/_____/_____ Number of days in cycle: _____ Are you pregnant? ☐ Yes ☐ No ☐ Unsure

All questions contained in this questionnaire are STRICTLY CONFIDENTIAL and will become part of your medical record at our office.