

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?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> 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:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Other _____ | |

Surgeries:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Radical prostatectomy | <input type="checkbox"/> Transurethral prostate surgery |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Other _____ | |

Allergies:

- | | | | |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | <input type="checkbox"/> Other _____ |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seat belts never | <input type="checkbox"/> Wear seatbelts usually |

Family History:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | <input type="checkbox"/> Other _____ | |

Substance Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (Present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | <input type="checkbox"/> Other _____ | |

Male Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Female Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Occupational Activities:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |
| <input type="checkbox"/> Military | <input type="checkbox"/> Police/fire | <input type="checkbox"/> Professional Service | <input type="checkbox"/> Teacher |

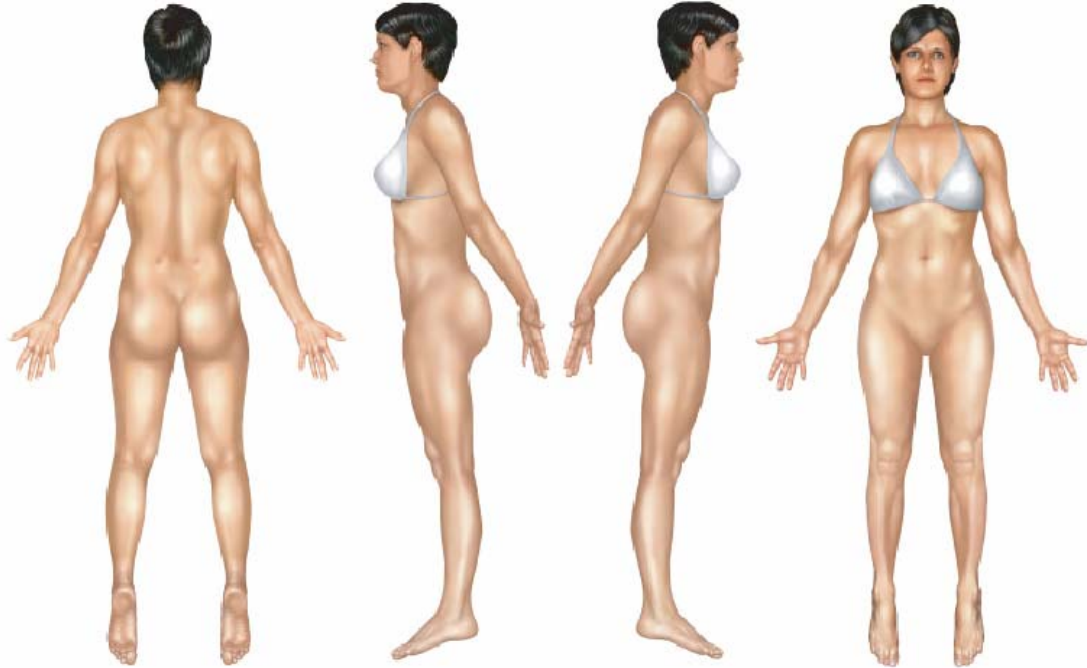
Truck driver Other _____

Recreational Activities:

- | | | | |
|--------------------------------------|---|--|-----------------------------------|
| <input type="checkbox"/> Backpacking | <input type="checkbox"/> Biking | <input type="checkbox"/> Boating | <input type="checkbox"/> Football |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Racket ball | <input type="checkbox"/> Rock climbing | <input type="checkbox"/> Running |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Weight lifting | <input type="checkbox"/> 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?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

What describes the nature of your symptoms?

- | | | | |
|----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull ache | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | |

How are your symptoms changing?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Getting better | <input type="checkbox"/> Not changing | <input type="checkbox"/> Getting worse |
|---|---------------------------------------|--|

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- | | | | |
|---------------------------------|----------------------------|--|----------------------------|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 |
| <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 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.