

# Carmen M Clemenson, D.C.

Clemenson Chiropractic  
960 Barrington Pkwy  
Marion IA 52302  
Telephone: (319) 377-1043  
Fax: (319) 377-8180

## Patient Information

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Nickname \_\_\_\_\_  
Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_ Cell Phone( ) \_\_\_\_\_  
Best time to reach you \_\_\_\_\_ On what phone Home Work Cell  
E-mail \_\_\_\_\_ SS# \_\_\_\_\_ Gender: Male Female  
Marital Status: Single Married Widowed Divorced Legally Separated Partnered  
Race/Ethnicity: African American Asian Caucasian Hispanic/Latino Native American  
Native Hawaiian/Pacific Islander Other Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_ Cell Phone( ) \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Referred by \_\_\_\_\_

## Patient Condition

Reason for visit \_\_\_\_\_  
What was the cause? \_\_\_\_\_  
When did your symptoms first appear? \_\_\_\_\_  
Did it begin: suddenly gradually worsened over time  
Have you had this problem before? yes no  
Describe the pain: achy burning dull sharp stiff throbbing other \_\_\_\_\_  
Describe the frequency: constant frequent intermittent occasional  
Does the pain travel? yes no If yes, to where? \_\_\_\_\_  
When does the pain feel worse? morning as day progresses afternoon evening sleep  
no change it hurts constantly  
What makes the pain worse? resting sleeping walking bending working  
movement in general sitting  
When does the pain improve? morning as day progresses afternoon evening sleep  
Describe any location of numbness. \_\_\_\_\_  
Describe any location of spasm. \_\_\_\_\_  
Describe any location of weakness. \_\_\_\_\_  
Do you notice any swelling? yes no If yes, where? \_\_\_\_\_  
Do you suffer from headaches? yes no  
If so, where are they typically located? forehead side back below skull bone  
What part of the day are the headaches at the worst? morning as day progresses afternoon  
evening sleep constant.  
How Frequent are the headaches? \_\_\_\_\_ times per week month year

## Activities of Daily Living

Does your pain keep you from dressing without assistance? yes no  
Does your pain keep you from grooming without assistance? yes no