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WELCOME

Patient Information

Name: (Last, First, MI) _____ Date of Birth: _____

Home Address: _____ SS#: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partner

Home: (____)_____ Mobile: (____)_____ Work: (____)_____

Leave messages on answering machine? ☐ Yes ☐ No Call your work & leave a message? ☐ Yes ☐ No

Email: _____ Family Physician: _____

Emergency Contact

Contact Name:_____ Relationship: _____ Phone: (____)_____

Employment Information

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ PT Student ☐ FT Student

Employer/School: _____ Occupation: _____

Address: _____ Phone: (____)_____

Insurance Information

Insurance Carrier: _____ Member ID#: _____

Primary Policy Holder: _____ Primary's DOB: _____ Relationship: _____

Present Condition

Primary Complaint: _____

When did your symptoms appear? _____

Are your symptoms getting progressively worse? ☐ Yes ☐ No

Mark an "**X**" on the picture where you experience pain, numbness or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain (check all that apply) ☐ Aching ☐ Burning ☐ Cramping ☐ Dull

☐ Numbness ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Swelling ☐ Throbbing

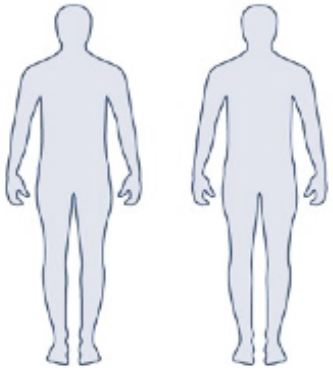
Is Your Pain: ☐ Constant ☐ Intermittent ☐ Occasional ☐ Periodic

Have You Experienced a Similar Problem Before? ☐ Yes ☐ No

Does it interfere with (check all that apply) ☐ Work ☐ Sleep ☐ Daily Routine ☐ Exercise

Activities or movements are painful to perform (check all that apply) ☐ Sitting ☐ Standing

☐ Walking ☐ Bending ☐ Lying Down ☐ Overhead Chores ☐ Bathing/Showering



Prior treatment for this problem: ☐ None ☐ Chiropractic ☐ Physical Therapy ☐ Massage Therapy

☐ Acupuncture ☐ Pain Medication ☐ Surgery ☐ Injections, if yes, date received; _____

Name & address of other doctor(s) who have treated you for your condition: _____

_____

Prior Tests: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ Lab Work ☐ Other: _____

Health History

List all CURRENT illnesses/diseases you have been diagnosed with (cancer, tumors, infections, diabetes, aneurysms, etc)

_____

If you are currently taking any prescription medications, please list them below with dosages

Medication: _____ Dose _____ Medication: _____ Dose _____

Medication: _____ Dose _____ Medication: _____ Dose _____

If you are currently taking any vitamins/herbs/minerals, please list them below

Supplement: _____ Supplement: _____

Supplement: _____ Supplement: _____

Please list any medications that you are allergic to: _____

Are you allergic to: Latex? ☐ Yes ☐ No Scents? ☐ Yes ☐ No Menthol? ☐ Yes ☐ No

Please indicate your current height: _____ weight: _____ What is your usual blood pressure _____/_____

Have you ever had the following procedures: ☐ Appendectomy (Appendix) ☐ Cholecystectomy (Gallbladder)

List any operations, surgeries or medical procedures:

Procedure: _____ Date _____ Procedure: _____ Date _____

Procedure: _____ Date _____ Procedure: _____ Date _____

If you have ever had in the past or currently have any serious illnesses or injuries, please list:

Condition: _____ Date _____ Condition: _____ Date _____

Condition: _____ Date _____ Condition: _____ Date _____

Current loss of bowel or bladder control: ☐ Yes ☐ No Current seizures or paralysis: ☐ Yes ☐ No

Unexplained weight loss: ☐ Yes ☐ No Current nutritional problems: ☐ Yes ☐ No Fever: ☐ Yes ☐ No

Please list any significant family illnesses _____

Do you have a pacemaker? ☐ Yes ☐ No If yes, please ALERT our doctor and/or chiropractic assistant

Do you have any blood/lymph disorders? ☐ Yes ☐ No If yes, please list _____

Do you have osteoporosis or rheumatoid arthritis? ☐ Yes ☐ No

Do you currently have any open wounds/sores? ☐ Yes ☐ No If Yes, Where? _____

Please select ONE: ☐ Never smoked ☐ Former Smoker ☐ Current smoker, if so how much: ____pk./day ____pk./wk.

Please select ONE: ☐ Don't drink alcohol ☐ Rarely Drink ☐ Social Drinker ☐ Heavy Drinker (___oz. per day/week)

WOMEN ONLY: To the best of my knowledge: ☐ **I am** ☐ **I am not pregnant** If so, how many weeks? _____

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition, as he/she deems appropriate through the use of Chiropractic care.

Patient Signature _____ **Date** _____