FAYETTEVILLE FAMILY CHIROPRACTIC

PLEASE FILL OUT COMPLETELY

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. Rank_____ Other_____

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____**City** _____

State _____ **Zip Code**_____ **Employer:** _____

Primary Phone: _____ **SSN:** _____

Secondary Phone: _____ **Mobile Phone:** _____

Home Email: _____ **Work Email:** _____

***By providing my email address, I authorize my doctor to contact me via the email address(es) provided**.*

Contact Method *(check one)* ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Would you like us to TEXT message you? *(Check one)* ❑YES ❑ NO **Cell Phone Provider:** _____

Who referred you to our office? _____

Your Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female

Spouse's Name _____ **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

Insurance Carrier _____ **Policy Number** _____

Primary Care Providers Name _____**Insured's Name** _____

Race *(check one)* ❑ White ❑ Black/African American ❑ Hispanic ❑ Asian ❑ Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Other _____ ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?

❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?

❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

Have you had previous Chiropractic care? ❑ Yes ❑ No

If yes, when was your last visit and where? _____

Have you had an X-ray, CT scan, or MRI of your back or neck in the past 12 months? ❑ Yes ❑ No

What activity do you enjoy that has become difficult due to this problem? _____

Fayetteville Family Chiropractic _____ Patient Health History

PRINT YOUR NAME AND DATE HERE

Briefly list your main health problem_____

When did this problem start? _____ **Have you had this problem before?** _____

Problem is due to: ❑Auto accident ❑Injury ❑Work related ❑Long-term problem ❑Other_____

Intensity of current symptoms? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 (worst)

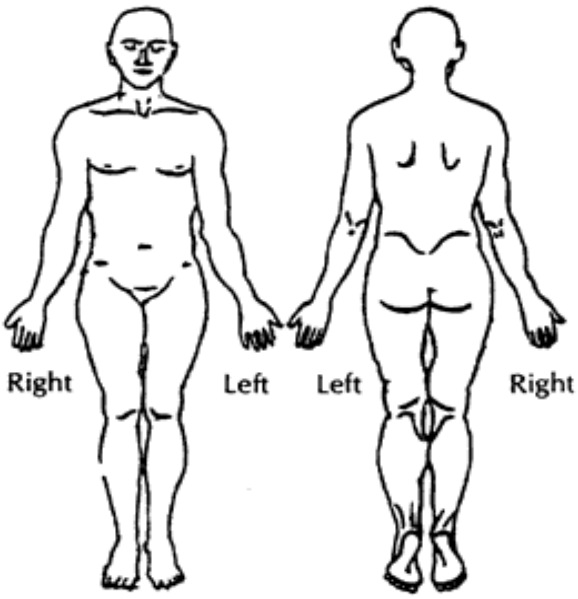
Duration and Timing of pain? ❑ Off & On ❑ Frequent ❑ Intermittent ❑Constant ❑Random ❑Recurring

What is most affected? = ❑Employment ❑Homemaking ❑Personal Care ❑Sitting ❑Sleeping ❑Standing ❑Social life ❑Traveling ❑Walking ❑Other _____

Due to this problem what is difficult?

❑ Bending Over	❑ Driving Car	❑ Household chores	❑ Showering/bathing	❑ Walking
❑ Climbing Stairs	❑ Exercising	❑ Lifting objects	❑ Sitting	❑ Yard work
❑ Caring for family	❑ Getting in/out of car	❑ Looking over shoulder	❑ Standing	❑ Other_____
❑ Concentrating	❑ Getting to sleep	❑ Lying down	❑ Staying asleep	
❑ Dressing self	❑ Grocery shopping	❑ Raising out of chair or bed	❑ Using a computer	

Location of pain -Circle areas where it hurts



Illnesses: Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	
❑	❑	Diabetes Type1__Type II___
❑	❑	Stroke
❑	❑	Other: _____

Injuries: Have you ever…

❑ Had a fractured or broken bone. Date_____
❑ Had a spine or nerve disorder. Date _____
❑ Been knocked unconscious. Date _____
❑ Been injured in an accident. Date _____
❑ Used neck or back bracing. Date _____

Quality of Symptoms
(What does it feel like?)

❑ Achy
❑ Annoying
❑ Burning
❑ Deep
❑ Diffuse
❑ Dull
❑ Heavy
❑ Intolerable
❑ Pulling
❑ Sharp
❑ Shock like
❑ Stabbing
❑ Stiffness
❑ Throbbing
❑ Tightness
❑ Tingling
❑ Other_____

Relieving Factors (What makes it better?)

❑ Chiropractic
❑ Heat
❑ Ice
❑ Exercise
❑ Support
❑ Massage
❑ Nothing
❑ OTC medication
❑ Rx medication
❑ Physical therapy
❑ Rest
❑ Stretching
❑ Work
❑ Other_____

Aggravating Factors (What makes it worse?)

❑ Any movement
❑ Bathing
❑ Bending
❑ Caring for family
❑ Carrying objects
❑ Climbing stairs
❑ Computer use
❑ Concentrating
❑ Coughing/sneezing
❑ Daily child/pet care
❑ Driving
❑ Eating
❑ Falling/staying asleep
❑ Getting in/out of car
❑ Getting up from lying down
❑ Grocery shopping
❑ Getting up from sitting
❑ Household chores
❑ Lifting
❑ Looking over shoulder
❑ Lying down
❑ Pushing
❑ Pulling
❑ Reaching
❑ Reading
❑ Resting
❑ Running
❑ Sitting
❑ Squatting
❑ Standing
❑ Stress
❑ Stretching
❑ Talking on the phone
❑ Turning
❑ Twisting
❑ Walking
❑ Working
❑ Yard work
❑ Other_____

What else should the doctor know about your current condition?_____

Current Medications (Rx & OTC)	What medication is treating	Frequency & Dosage	Start date

Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. **Please put a check (☑) beside any condition that you've Had or currently Have.**

Musculoskeletal

Had	Have	
❑	❑	Osteoporosis
❑	❑	Knee Injuries
❑	❑	Arthritis
❑	❑	Foot/ankle pain
❑	❑	Scoliosis
❑	❑	Shoulder problems
❑	❑	Neck Pain
❑	❑	Elbow/ wrist pain
❑	❑	Back problems
❑	❑	TMJ issues
❑	❑	Hip disorders
❑	❑	Cramping
❑	❑	Gout
❑	❑	Poor posture
❑	❑	Swelling/deformity of joints

Neurological

Had	Have	
❑	❑	Anxiety/ Panic
❑	❑	Depression
❑	❑	Headache/ Migraines
❑	❑	Dizziness
❑	❑	Pins and Needles
❑	❑	Numbness
❑	❑	Difficulty concentrating
❑	❑	Epilepsy/ seizures
❑	❑	Loss of smell/taste
❑	❑	Memory issues
❑	❑	Sleeping issues
❑	❑	Stroke
❑	❑	Weak muscles
❑	❑	Temporary loss of: Vision, smell, or hearing

Head and ENT

Had	Have	
❑	❑	Blurred/ double vision
❑	❑	Chronic ear infections
❑	❑	Dental problems
❑	❑	Difficulty swallowing
❑	❑	Ear/ hearing problems
❑	❑	Earache
❑	❑	Hoarseness
❑	❑	Sinus Trouble
❑	❑	Recent hearing loss
❑	❑	Ringing in the ears
❑	❑	Sore throat
❑	❑	Swollen lymph nodes

Cardiovascular

Had	Have	
❑	❑	Blood clots
❑	❑	Chest pain/ tightness
❑	❑	Congenital heart defects
❑	❑	Coronary artery disease
❑	❑	Dizziness
❑	❑	Heart attack
❑	❑	High blood pressure
❑	❑	High cholesterol
❑	❑	Leg pain upon walking
❑	❑	Low Blood Pressure
❑	❑	Lower extremity edema
❑	❑	Palpitations

Dermatological

Had	Have	
❑	❑	Psoriasis
❑	❑	Eczema
❑	❑	Excessive hair loss
❑	❑	Skin cancer
❑	❑	Skin trouble/ rashes
❑	❑	Change in hair/ nails

Genitourinary

Had	Have	
❑	❑	Blood in the urine
❑	❑	Incontinence
❑	❑	Kidney stones
❑	❑	Urgency
❑	❑	Painful/frequent urination

Endocrine

Had	Have	
❑	❑	Excessive thirst
❑	❑	Hyperparathyroidism
❑	❑	Increase urination
❑	❑	Pancreatic Conditions
❑	❑	Steroid Treatments
❑	❑	Testosterone deficiency
❑	❑	Thyroid problems

Digestive

Had	Have	
❑	❑	Abdominal pain
❑	❑	Black/ bloody stool
❑	❑	Changes in bowel habits
❑	❑	Colitis
❑	❑	Colon cancer or polyps
❑	❑	Constipation
❑	❑	Difficulty swallowing
❑	❑	Gastric reflux
❑	❑	Heartburn
❑	❑	IBS
❑	❑	Jaundice
❑	❑	Liver disease
❑	❑	Nausea/ vomiting
❑	❑	Pancreatitis
❑	❑	Severe diarrhea
❑	❑	Ulcer

Respiratory

Had	Have	
❑	❑	Asthma
❑	❑	Apnea
❑	❑	Emphysema
❑	❑	Shortness of Breath
❑	❑	Pneumonia
❑	❑	Persistent cough
❑	❑	Snoring issues
❑	❑	Tuberculosis
❑	❑	Hay Fever
❑	❑	Wheezing

Surgeries, which may or may not have included hospitalization and Dates

- ❑ Bypass surgery _____
- ❑ Cancer _____
- ❑ Elective surgery _____
- ❑ Hysterectomy _____
- ❑ Pacemaker_____
- ❑ Spine_____
- ❑ Wisdom teeth_____
- ❑ Other: _____

Family History: Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age	Illnesses	Age of death	Cause of death
Mother				
Father				
Sister1				
Sister2				
Brother1				
Brother2				

Social History Tell us about your health habits and stress levels. Please write N/A if it doesn't apply to you.

Employment Status == Occupation _____ Hours per week _____ Change due to current problem _____

Do you smoke? ____ **Yes** ____**No** **How long?**_____ **Packs a day?** ____ **How long since you stopped?**_____

How interested are you in quitting? - Please Circle: No 1 2 3 4 5 6 7 8 9 10 Yes

Alcohol use -- ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Alcoholic ❑ Recovering alcoholic

Recreational Drug use -- ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Drug addicted ❑ Recovering drug addict

Caffine use -- ❑ None ❑ 1cup/day ❑2-4cups/day ❑ 5+cups/day

Exercise habits -- ❑ None ❑ Daily ❑ 2-3 times a week ❑ Weekly ❑ Occasionally Type?_____

Is your diet restricted?_____ Any recent change in diet?_____

Any Change in social habits due to current issue?_____

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELL-BEING

_____ I am only concerned about relief of a particular symptom.

_____ I am only concerned about relief of a particular symptom and preventing its return.

_____ I want optimum health and well-being on every level available to me