**PLEASE FILL OUT COMPLETELY**

 **Check in PIN #:**

 **(6 digits)**

**Patient Title:** *(check one)*  ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. Rank\_\_\_\_\_\_ Other\_\_\_\_\_\_\_

**First Name** **Nick Name**

**Last Name Middle Name**

**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\*\*.*

**How were you referred to our office?**

 / /

**Your Date of Birth Age**  **Gender** *(check on* ❑ Male ❑ Female ❑ Other

**Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status** *(check one)* ❑ Single ❑ Married

 ❑ Widowed ❑ Divorced

**Spouse’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Providers Name \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**I authorize to receive any medical or billing information in my account.**

*Signature required at the bottom of this form for this authorization to be valid.*

**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?**

**Other doctors seen for this problem (please list): Chiropractor:**

**Medical Doctor: Other:**

**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

 / /

**Today’s Date Signature of Patient**

**Briefly list your main chief complaint \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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?**    (better)  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 ❑Lifting

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

|  |
| --- |
| **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 |  |  |  |  |
| Sister |  |  |  |  |
| Brother |  |  |  |  |
| Children |  |  |  |  |
| Children |  |  |  |  |
| Children |  |  |  |  |

**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 \_\_\_\_\_\_\_\_

**Illnesses:** Check the illnesses you have

**Had** in the past or **Have** now.

**Had Have**

 ❑ ❑ Diabetes Type1\_\_Type II\_\_\_

 ❑ ❑ Stroke

 ❑ ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Aggravating Factors** (What makes it worse?)

❑ Any movement ❑ Looking over shoulder

❑ Bathing ❑ Lying down

❑ Bending ❑ Pushing

❑ Caring for family ❑ Pulling

❑ Carrying objects ❑ Reaching

❑ Climbing stairs ❑ Reading

❑ Computer use ❑ Resting

❑ Concentrating ❑ Running

❑ Coughing/sneezing ❑ Sitting

❑ Daily child/pet care ❑ Squatting

❑ Dressing self ❑ Standing

❑Driving ❑ Stress

❑ Eating ❑ Stretching

❑ Exercises ❑ Talking on the phone

❑ Falling/staying asleep ❑ Turning

❑ Getting in/out of car ❑ Twisting

❑ Getting up from lying down ❑ Walking

❑ Grocery shopping ❑ Working

❑ Getting up from sitting ❑ Yard work

❑ Household chores ❑ Other\_\_\_\_\_\_ \_

❑ Lifting

**Relieving Factors** (What makes it better?)

❑ Chiropractic

❑ Heat

❑ Ice

❑ Exercise

❑ Support

❑ Massage

❑ Nothing

❑ OTC medication

❑ Rx medication

❑ Physical therapy

❑ Rest

❑ Stretching

❑ Work

❑ Other\_\_\_\_\_\_

**Quality of Symptoms**

(What does it feel like?)

❑ Achy

❑ Annoying

❑ Burning

❑ Deep

❑ Dull

❑ Heavy

❑ Intolerable

❑ Pulling

❑ Sharp

❑ Shock like

❑ Stabbing

❑ Stiffness

❑ Throbbing

❑ Tightness

❑ Tingling

❑ Other\_\_\_\_\_\_\_\_\_

**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

 ❑ ❑ Poor posture

 ❑ ❑ Swelling/deformity of joints

**Digestive**

**Had Have**

 ❑ ❑ Abdominal pain

 ❑ ❑ Black/ bloody stool

 ❑ ❑ Changes in bowel habits

 ❑ ❑ Colon cancer or polyps

 ❑ ❑ Constipation

 ❑ ❑ Gastric reflux

 ❑ ❑ Heartburn

 ❑ ❑ IBS

 ❑ ❑ Liver disease

 ❑ ❑ Nausea/ vomiting

 ❑ ❑ Diarrhea

 ❑ ❑ Ulcer

**Cardiovascular**

**Had Have**

 ❑ ❑ Blood clots

 ❑ ❑ Chest pain/ tightness

 ❑ ❑ Coronary artery disease

 ❑ ❑ Heart attack

 ❑ ❑ High blood pressure

 ❑ ❑ High cholesterol

 ❑ ❑ Leg pain upon walking

 ❑ ❑ Low Blood Pressure

 ❑ ❑ Lower extremity edema

 ❑ ❑ Palpitations

**Neurological**

**Had Have**

 ❑ ❑ Anxiety/ Panic

 ❑ ❑ Depression

 ❑ ❑ Headache/ Migraines

 ❑ ❑ Dizziness

 ❑ ❑ Pins and Needles

 ❑ ❑ Numbness

 ❑ ❑ Epilepsy/ seizures

 ❑ ❑ Memory issues

 ❑ ❑ Stroke

 ❑ ❑ Weak muscles

 ❑ ❑ Temporary loss of:

 Vision, smell, or hearing

**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 smoking? \_\_\_\_\_\_\_\_\_\_\_\_**

**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

**Caffeine 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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Endocrine**

**Had Have**

 ❑ ❑ Excessive thirst

 ❑ ❑ Testosterone deficiency

 ❑ ❑ Thyroid problems

**Head and ENT**

**Had Have**

 ❑ ❑ Blurred/ double vision

 ❑ ❑ Difficulty swallowing

 ❑ ❑ Ear/ hearing problems

 ❑ ❑ Sinus Trouble

 ❑ ❑ Ringing in the ears

 ❑ ❑ Swollen lymph nodes

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

❑ Bypass surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Elective surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Hysterectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Pacemaker\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Spine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Wisdom teeth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genitourinary**

**Had Have**

 ❑ ❑ Blood in the urine

 ❑ ❑ Incontinence

 ❑ ❑ Kidney stones

 ❑ ❑ Urgency

 ❑ ❑ Painful/frequent urination

 **Respiratory**

**Had Have**

 ❑ ❑ Asthma

 ❑ ❑ Emphysema

 ❑ ❑ Shortness of Breath

 ❑ ❑ Persistent cough

 ❑ ❑ Wheezing

 ❑ ❑ Breathing Difficulties

**Dermatological**

**Had Have**

 ❑ ❑ Psoriasis

 ❑ ❑ Eczema

 ❑ ❑ Excessive hair loss

 ❑ ❑ Skin cancer

 ❑ ❑ Skin trouble/ rashes

 ❑ ❑ Change in hair/ nails