PATIENT INFORMATION

Please answer each of the following questions as completely as possible.

Name:_____ **Date of Birth:**___/___/_____ ☐M ☐S ☐W ☐D
Address:_____ **City:**_____ **State:**____ **Zip:**_____
E-mail Address: _____ **Soc. Sec. #:**_____
Cell Ph:_____ **Home Ph:**_____ **Work Ph:**_____
Employer:_____ **Spouse:**_____ **Referred By:**_____
Emergency Contact: _____ **Phone:**_____ **Relationship:**_____

1. Presenting Concerns

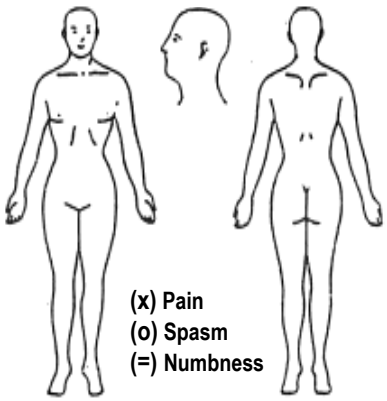
Describe the specific reason(s) for your visit today. . .

*1.*_____
*2.*_____
*3.*_____

Important! Mark the location, quality and the severity, of your complaint(s).

Complete below as detailed as Possible

Location



Quality

☐ Ache
☐ Sharp
☐ Throb
☐ Burn
☐ Numb
☐ Tingle
☐ Radiating
☐ Swollen
☐ Spasm
☐ Stiff
☐ Weak
☐ Other

Severity

Low
1 ☐
2 ☐
3 ☐
4 ☐
5 ☐
6 ☐
7 ☐
8 ☐
9 ☐
0 ☐
High

How often do you experience these symptoms?
☐ Constant ☐ Frequently ☐ Occasionally

Describe the health concern that prompted this visit? _____
How has this concern(s) changed since onset? ☐ Better ☐ Worse ☐ Remaining the Same
What caused the above concern(s)? _____
What currently aggravates concern(s)? _____
What seems to improve concern(s)? _____
Have you experienced previous episodes of this condition? ☐ No ☐ Yes When? _____
Have you seen other doctors for the above? ☐ No ☐ Yes Who? _____
What was diagnosis? _____ What was recommended? _____

2. Work & Lifestyle

Does this affect your daily / work activities? ☐ No ☐ Yes How? _____
Does this affect your social / family activities? ☐ No ☐ Yes How?_____
Does this affect your sleep? ☐ No ☐ Yes How? _____

3. Environmental Stressors

What are your primary job requirements (e.g.: lifting, computer, walking, etc.) _____
Are you exposed to toxic chemicals at work or at home? ☐ No ☐ Yes Discribe:_____
Do you currently take any medications for **this** complaint? ☐ No ☐ Yes What?_____
Do you exercise, workout, or play sports? ☐ Not at all ☐ Regularly ☐ Periodically What:_____

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Please Complete Other Side. . .

4. Your Past Health History

Please **check (✓) any health issues that you have experienced:**

- ☐ Low Back Pain
- ☐ Middle Back Pain
- ☐ Neck Pain
- ☐ Hip / Leg Pain
- ☐ Joint Pain
- ☐ Shoulder /Arm Pain
- ☐ Headaches
- ☐ Sleep Disorders
- ☐ Weak Muscles
- ☐ Urinary Problems
- ☐ Weight Loss / Gain
- ☐ Mood swings
- ☐ Nervousness
- ☐ Throat / Voice
- ☐ Numbness
- ☐ Dizziness
- ☐ Seizures
- ☐ Shaking/Tremors
- ☐ Coughing or Wheezing
- ☐ Excessive Thirst
- ☐ Genital Pain
- ☐ Heartburn
- ☐ Eyes / Vision
- ☐ Ears / Hearing
- ☐ Sinus Pain / Drainage
- ☐ Blood Pressure
- ☐ Cold Hands / Feet
- ☐ Poor Circulation
- ☐ Chest Pain
- ☐ Lungs/Breathing
- ☐ Dental / TMJ
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation

Female Only

- ☐ Menstrual Problems
- ☐ Back Pain w/ Period
- ☐ Birth Control Pills
- ☐ Breast Lumps
- ☐ Breast Implants
- ☐ Breast Pain

Is there any possibility you are pregnant? ☐Yes ☐No

Have you had any previous traumas / injuries? ☐No ☐Yes

Have you been in an automobile accident? ☐No ☐Yes

Have you had any previous surgeries? ☐No ☐Yes

Have you had any joint injuries or broken bones? ☐No ☐Yes

5. Your Family Health History

Is there a family history of: ☐ Cancer ☐ Diabetes ☐ Heart or Stroke ☐ Lung ☐ Obesity ☐ Other: _____

Has anyone in your family expressed similar health concerns as those for which you are consulting us? ☐No ☐Yes

Are you concerned about the health of any member of your family for any reason? ☐No ☐Yes

6. Your General Health

	No	Yes	Please Explain:
Have you missed work in the past year due to a health issue?	☐	☐	_____
Do you experience a cold or the flu more than once a year?	☐	☐	_____
Do you regularly use any medications for pain?	☐	☐	_____
Do you take vitamins regularly?	☐	☐	_____

How well do you deal with stress?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How is your diet?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How are your energy levels?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How do you feel your posture is?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How is your attitude towards life?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How restfully do you sleep?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How many hours of sleep / night:	☐ 0-4 hours	☐ 5-8 hours	☐ more than 8 hours	

How would you rate your overall health today compared to five years ago? ☐ Same ☐ Better ☐ Worse

Please mark the appropriate circle:

In general, how would you rate your overall health & vitality?

(Challenged) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (High)

In general how would you rate your levels of daily stress?

At Work: (Low) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (High)

At home: (Low) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (High)

Our recommendations for your care are always based on **your** health objectives. What best describes your current objectives?

- ☐ **Relief Care** - I only want symptom relief. I am not interested in improving my health or in long-term correction of the cause.
- ☐ **Corrective Care** - I am interested in correcting the causes of my health concerns and rebuilding strength and stability.
- ☐ **Health / Wellness Care** – I am interested in improving and maintaining my health, vitality, and lifestyle.

I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therfore, the above information is true and complete to the best of my knowledge. I also verify that I am not seeking care for any worker's comp, automobile accident, or third party pay injury. I hereby authorize the release of all HIPAA protected health information to my personal insurance carrier or to any party who may become liable for my care. I hereby request and give permission for this office to examine, evaluate, and render chiropractic care for the above mentioned health concerns.

_____ _____

Patient / Guardian Signature *Date*