Welcome

Patient Information

Date_____

SS/HIC/Patient ID #_____

Patient Last Name_____

Patient First Name_____

Address_____

City_____State_____ Zip Code_____

Email_____

Sex ◯ Male ◯ Female Age_____

Birthdate_____

◯ Married ◯ Widowed ◯ Single ◯ Divorced ◯ Minor

Home Phone (_____)_____

Cell Phone (_____)_____

Occupation_____

Patient Employer/School_____

Employer/School Address_____

Employer/School Phone (____)_____

Spouse's Name_____Birthdate_____

Whom may we thank for referring you?_____

In Case of Emergency, Contact

First Name_____

Last Name_____

Relationship_____

Cell Phone (____)_____

Home Phone (____) _____

Work Phone (____)_____

Accident Information

Is the condition due to an accident? ◯ Yes ◯ No

Date of the Accident_____

Type of Accident ◯ Auto ◯ Work ◯ Home

◯ Other

To whom have you made a report of your accident?

◯ Auto Insurance ◯ Employer ◯ Worker Comp.

◯ Other

Attorney Name (if applicable)_____

_____

Patient Condition

Reason for Visit_____ When did you symptoms appear?_____

Is this condition progressively getting worse? ◯ Yes ◯ No ◯ Unknown

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

Type of pain: ◯ Sharp ◯ dull ◯ throbbing ◯ Numbness ◯ aching ◯ shooting ◯ burning

◯ Tingling ◯ Cramps ◯ Stiffness ◯ Swelling ◯ Other _____

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

Activities or movements that are painful to perform

◯ Sitting ◯ Lying down ◯ Walking ◯ Bending

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Doctors Comments_____

_____

Health History

What treatment have you already received for you condition(s)? ◯ Surgery ◯ Physical Therapy ◯ Chiropractic

◯ None ◯ Other _____

Name and Address of your current primary doctor _____

Date of Last: Physical Exam_____ Spinal X-ray_____ Blood Test_____ Spinal Exam _____

Chest X-ray _____ Urine Test_____ Dental X-ray _____ MRI, CT- Scan, Bone Scan _____

Please mark the circle if any of these currently or in the past apply to you:

◯ AIDS/ HIV	◯ Diabetes	◯ Liver Disease	◯ Rheumatoid Arthritis
◯ Alcoholism	◯ Emphysema	◯ Measles	◯ Rheumatic Fever
◯ Allergy Shots	◯ Epilepsy	◯ Migraine Headaches	◯ Scarlet Fever
◯ Anemia	◯ Fractures	◯ Miscarriage	◯ Sexually Transmitted Disease
◯ Anorexia	◯ Glaucoma	◯ Mononucleosis	◯ Stroke
◯ Appendicitis	◯ Goiter	◯ Multiple Sclerosis	◯ Suicide Attempt
◯ Arthritis	◯ Gonorrhea	◯ Mumps	◯ Thyroid Problems
◯ Asthma	◯ Gout	◯ Osteoporosis	◯ Tonsillitis
◯ Bleeding Disorders	◯ Heart Disease	◯ Pace Maker	◯ Tuberculosis
◯ Breast Lump	◯ Hepatitis	◯ Parkinson's disease	◯ Tumors, Growths
◯ Bronchitis	◯ Hernia	◯ Pinched Nerve	◯ Typhoid Fever
◯ Bulimia	◯ Herniated Disk	◯ Pneumonia	◯ Ulcers
◯ Cancer	◯ Herpes	◯ Polio	◯ Vaginal Infections
◯ Cataracts	◯ High Blood Pressure	◯ Prostate Problem	◯ Whooping Cough
◯ Chemical Dependency	◯ High Cholesterol	◯ Prosthesis	◯ Other_____
◯ Chicken Pox	◯ Kidney Disease	◯ Psychiatric Care	_____

Exercise

◯ None

◯ Moderate

◯ Daily

◯ Heavy

Work Activity

◯ Sitting

◯ Standing

◯ Light Labor

◯ Heavy Labor

Habits

◯ Smoking Packs/ Day_____

◯ Alcohol Drinks/ Week_____

◯ Coffee/ Caffeine Drinks Cups/ Day _____

◯ High Stress Level Reason_____

Are You Pregnant? ◯ Yes ◯ No

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