CONFIDENTIAL PATIENT INFORMATION

Name____Date_________________________
Address______________________________City_______________________State_____Zip______
Cell Phone (Primary Phone) (_____)_______________E-mail ___________________________ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) Birthdate_____________Age_____

SS#_________________________________Driver's License Number___________________________
Health Insurance (Name)____
Business/Employer__________________________Address__________________City_____________
Type of Work_____________________ ☐ Full or ☐ Part Time Business Phone (_____)_____________Ext.____

Person Responsible For This Account____________________Referred To This Office By_______________
Nearest Relative Not Living With You___________________________Phone (______)_______________
Name of Emergency Contact______________________Relationship__________ Phone (_____)___________
Spouse's Name____________________________________Birthdate___________SS#______________
Spouse's Employer_________________________Spouse's Cell Phone (______)___________________
What Is Your Major Complaint?____
When Did This Condition Begin?_______________Has This Condition Occurred Before? ☐ Yes ☐ No

List Any Activities, Accidents or Injuries That Contributed to the Onset of Your Condition__________________
____
Is Your Condition ☐ Job Related ☐ Auto Related ☐ Home Injury ☐Fall ☐Other______________________

Date Of Accident_____________________________Time Of Accident__________________________
Have You Reported This Accident To Your Insurance Company, Employer or Auto Insurance? ☐ Yes ☐ No

What Activities Aggravate Your Condition?____
Is This Condition Interfering With ☐ Work ☐ Sleep ☐ Activities of Daily Living ☐ Other________________

How?____
Have You Seen Any Other Doctors For This Condition? ☐ Yes ☐ No Doctor's Name___________________

Diagnosis________________________Type Of Treatment____________________________________
Length Of Care_____________Are You Still Under Care?_________Results_______________________
Do You Wear A Shoe or Heel Lift? ☐ Yes ☐ No Do You Wear Orthotics? ☐Yes ☐ No

List Current Medical Conditions for Which You Are Being Treated Or Suffer From_______________________
____
Current Medications (Prescription and Over-the-Counter)____
____
Current Supplements (Vitamins, etc.)____
Previous Surgeries (Please Provide Dates) ____
____
Previous Accidents or Injuries (Please Provide Dates) (Especially Those That Relate to Your Current Problem…Falls, Broken Bones, Auto Accidents, Head Trauma, Sports Injuries, Etc.)_________________________________
____
Illnesses and/Or Hospitalizations____
Family History: List Medical Conditions That Your Parents and Siblings Suffer(ed) From__________________
____
Previous Chiropractic Care ☐ No ☐ Yes Doctor's Name________________________Date of Last Visit______

Were You Satisfied With Care? ____
Family Physician____Date of Last Visit_______

I understand and agree that all services rendered to me are charged directly to me and that I am PERSONALLY responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature_____________________________________Date_______________________
(Legal Guardian, If Minor)

PAST MEDICAL HISTORY: Place an "X" next to conditions that you currently or previously experience(d).

___Acid reflux or ulcers
___Anemia
___Aneurysm
___Arm pain
___Arthritis
___Allergies_____________
___Asthma or Bronchitis
___Alcoholism
___Alzheimer's disease
___Back pain
___Blood vessel disease

___Cancer________________
___Chronic fatigue
___Carpal Tunnel Syndrome
___Circulatory problems
___Colon problems
___Depression
___Diabetes
___Drug addiction
___Eating disorder
___Epilepsy/Seizures
___Fainting

___Fibromyalgia
___Glaucoma
___Headaches or migraine
___Heart attack
___Heart disease
___High blood pressure
___High cholesterol
___Herniated disk
___Kidney or bladder disease
___Leg pain
___Liver or gallbladder

___Low blood sugar
___Mental illness
___Neck pain
___Neurological problems
___Obesity
___Osteoporosis
___Sinus problems
___Skin problems
___Stroke or TIA
___Thyroid problems
Other___________________

Next to each symptom that you are currently experiencing, identify how often the symptom occurs by placing either an *0 = Occasional (Off and On), F = Frequent (Most of the time), or C = Constant (All of the time)*

HEAD
___Headache
___Sinus (allergy)
___Entire Head
___Back of Head
___Forehead
___Temples
___Migraine
___Loss of Memory
___Light-Headedness
___Fainting
___Light Bothers Eyes
___Blurred Vision
___Double Vision
___Loss of Vision
___Loss of Taste
___Loss of Balance
___Dizziness
___Loss of Hearing
___Pain in Ears
___Ringing in Ears

NECK
___Neck Pain
___Neck Stiffness
___Muscle Spasms
___Grinding Sounds
___Popping Sounds
Neck Pain with movement:
___Forward
___Backward
___Turn to Right
___Turn to Left
___Bend to Right
___Bend to Left

UPPER EXTREMITIES
___Shoulder Pain
___Tension in Shoulders
___Rotator Cuff Problems
___Difficult To Raise Arm
___To Shoulder Level
___Above Shoulder Level
___Pain in Upper Arm
___Elbow Pain
___Pain in Forearm
___Pain in Hands
___Pain in Fingers
___Numbness or Tingling in Arm
___Numbness or Tingling in Hands/Fingers
___Cold Hands
___Fingers go to Sleep
___Swollen Finger Joints
___Sore Finger Joints
___Arthritis in Fingers
___Loss of Grip Strength

UPPER BACK
___Upper Back Pain
___Pain between Shoulder Blades
___Pain from Front to Back

LOWER BACK
___Low Back Pain
___Muscle Spasms
___Herniated Disk
Aggravated By:
___Working
___Lifting
___Standing
___Sitting
___Bending
___Coughing/Sneezing
___Lying Down
___Walking
Other__________________
____
Relieved By____________
____

LOWER EXTREMITIES
___Pain in Buttocks
___Pain in Hip
___Leg Pain
___Knee Pain
___Leg Cramps
___Cramps in Feet
___Numbness or Tingling in Legs
___Numbness or Tingling in Feet/Toes
___Ankle Pain
___Foot Pain
___Swollen Ankles
___Swollen Feet
___Cold Feet

CHEST:
___Chest Pain
___Shortness of Breath
___Pain Around Ribs
___Breast Pain
___Dimpled Breast
___Irregular Heartbeat

ABDOMEN:
___Upset Stomach
___Nausea
___Gas
___Constipation
___Diarrhea
___Hemorrhoids
Problem Foods__________
____
____

WOMEN ONLY
Are You Pregnant?_______
___Menstrual Pain/Cramps
___Irregular Cycle
___Discharge
Birth Control (Type)______
____
Hysterectomy (when)_____
Cancer/Type:___________
Menopause_____________
Tumors________________
Abortions______________

MEN ONLY
___Frequent Urination
___Difficulty in Starting
___Night Urination
___Prostate Problems
Cancer/Type:__________

GENERAL
___Nervousness
___Irritable
___Depressed
___Fatigue
___Frequent Colds/Flu
Weight Loss____pounds
Weight Gain____pounds

HEALTH HABITS
Tobacco:
Cigarettes # / day________
Cigars # / day___________
Alcohol:
Wine #glasses/d or wk____
Beer #glasses/d or wk_____
Liquor #ounces/d or wk___
Caffeine:
Coffee #6 oz cups/d______
Tea #6 oz cups/d_________
Soda cans/d_____________
Other sources___________
Water: # glasses/d_______

EXERCISE
___5-7 days per week
___3-4 days per week
___1-2 days per week
___45 minutes or more
___30-45 minutes
___Less than 30 minutes
___Walk
___Run/Jog
___Weight lift
___Swim
___Bike
Other__________________