Dr. Michael M. Svensson
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Welcome to Quantum Chiropractic. Please take the time to fill out the forms carefully. The information you provide will help me understand your needs and concerns and will ensure that my staff has the necessary information needed for accounting and billing purposes. Thank you.

Patient's Full Name_____ Today's Date_____

Patient's Nickname_____ Patient's Date of Birth _____

Address_____ City _____

State_____ Zip_____ SS#_____

Occupation _____ Employer _____

Home Phone Number_____ Work Number _____

Cell Phone _____ E-mail Address _____

Contact Preference: □ Home Phone □ Work Phone □ Cell Phone

□ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Name of Spouse (name of parent or guardian, if patient is a minor):

_____ Birth date _____

Occupation _____ Employer _____

Home phone number_____ Work Number _____

Cell phone _____ E-mail Address _____

Emergency Contact_____

Have you had chiropractic care before? □ Yes □ No Last visit _____

Is your visit today due to a work related accident? □ Yes □ No

Is your visit today due to an auto accident? □ Yes □ No

Referred by _____

ID # _____
(for office use only)

History Form

Patient Name_____ Occupation_____

Date of Birth_____/_____/_____ Date_____

Chief Complaint_____
_____

Location of Pain/Symptoms_____
_____

Date/Time of Onset_____

What was patient doing at time of onset/prior to onset _____
_____

Quality of Pain Dull / Sharp Achy Throbbing Burning

Stabbing Shooting Numbness Tingling

Frequency/Duration_____
Radiation of Symptoms_____

Severity 0 1 2 3 4 5 6 7 8 9

What makes it better?

Time of day_____
Positions_____
Activities_____
Medications_____
Other therapies_____

What makes it worse?

Time of day_____
Positions_____
Activities_____
Ineffective medications/ therapies_____
_____

How does this affect ADL's (work, chores, recreational activities, sleep, etc….) _____
_____
_____

Associated Symptoms_____
Allergies_____

Medications (including OTC, supplements, recreational drugs, tobacco) _____
_____

Past History

Family Medical History (diabetes, cancer, etc…)_____
Similar/related conditions_____
Treatment (and effectiveness of treatment) _____
_____
Past Chiropractic/ Acupuncture Treatment_____
_____
Surgeries and Hospitalizations_____