PACKER CHIROPRACTIC 111 WASHINGTON STREET ~ P.O.BOX 369, NORTH EASTON, MASSACHUSETTS 02356
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CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions. Thank you.

(PLEASE PRINT)

Name: _____ Date: _____
Address: _____ Home Phone: _____
City, State: _____Zip:_____ Cell Phone: _____
Birth Date: _____ Age: _____ Sex: □ M □ F Driver's License # _____
E-Mail Address: _____
Employed by: _____Occupation: _____
Address: _____Work Phone: _____
How were you referred to this office? _____
Favorite Hobbies or Interest: _____
Marital Status: M W D S Spouse's Name: _____
Employed by: _____Occupation: _____
Address: _____Work Phone: _____
Children's Names & Ages: _____
Who is financially responsible for this bill? _____
Method of Payment: (Check One) □ Cash □ Check □ Credit Card □ Insurance: _____
List your chief complaints in order of severity:
1._____for how long? _____
Sharp Dull Ache Burning Throbbing Stabbing Shooting Numbness Tingling
2._____for how long? _____
Sharp Dull Ache Burning Throbbing Stabbing Shooting Numbness Tingling
3._____for how long? _____
Sharp Dull Ache Burning Throbbing Stabbing Shooting Numbness Tingling
Where is the pain? _____
Does the pain spread? □ Yes □ No If yes, where? _____
Do you have numbness? □ Yes □ No If yes, where? _____
Is there pain when you cough or sneeze? □Yes □ No If yes, where? _____
Is there pain when you go from sitting to standing? □ Yes □ No If yes, where? _____
Do you have any headaches? □ Yes □ No If yes, circle all that apply:
Tension Throb Sinus Migraine Other _____
Indicate any function below that aggravates or is aggravated by your condition: (Circle all that apply)

Walking Step Climbing Driving Working Recreation Bowel Movements Digestion
Breathing Sinuses Hearing Smelling Sleeping Vision If Female: Menstrual

Have you ever been to a chiropractor before? □ Yes □ No If yes, Who & When? _____
List other doctors that were consulted for these conditions: 1. _____
2._____ 3. _____
Previous diagnosis given: _____
List operations you have had:
1. _____ 2. _____ 3. _____
List serious illnesses you have had:
1. _____ 2. _____ 3. _____
Date of last physical examination: _____ Is there any chance you are pregnant? □ Yes □ No
Have you ever been diagnosed with cancer? □ Yes □ No If yes, what kind? _____
Medication you currently take: _____
Father, Mother, Brother, Sister, Children with similar problems? □ Yes □ No If yes, who: _____

Confidential: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e. TB, Hepatitis.

OVER

_____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Measles
- ☐ Anemia
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid
- ☐ Heart Disease
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Eczema
- ☐ Lumbago

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar
- ☐ Artificial Sweeteners

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTROINTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Over/Under Weight
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FEMALES ONLY

When was your last period?

_____

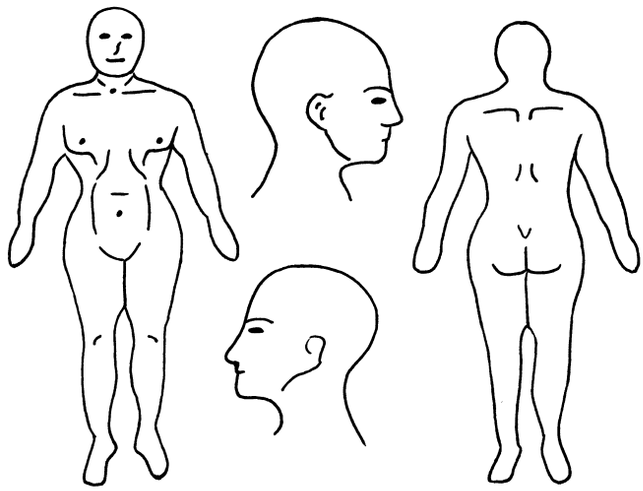
Are you pregnant?

☐ Yes ☐ No

FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

Please outline on the diagram the area of your discomfort:



FAMILY HISTORY

Health problems, if deceased, cause and age at death:

- ☐ Mother _____
- ☐ Father _____
- ☐ Brother _____
- ☐ Sister _____
- ☐ Spouse _____
- ☐ Child _____

_____ _____

Patients Signature (or Guardian's Signature if patient is a minor) Date

In case of emergency, please notify: _____Phone # _____

Name of nearest relative **not living with you**: _____

Relationship: _____Phone:_____Address:_____

_____