Welcome to Complete Chiropractic

Please fill out the following form in as much detail as possible. Please know that all information will be kept confidential.

Patient Information

Patient name _____

Today's date _____ Date of birth _____

Social Security # _____

Address _____

City _____

State _____ Zip _____

Gender: ❑ Male ❑ Female

❑ Single ❑ Married ❑ Partnered ❑ Engaged

❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

Occupation _____

Employer/School _____

Employer/School address _____

_____

Employer/School phone number (_____) _____

Spouse's/Partner's name _____

Spouse's/Partner's employer _____

Who referred you? _____

Contact Information

Home phone (_____) _____

Cell phone (_____) _____

Email address _____

May we contact you via (please check for all applicable):

❑ Home phone ❑ Cell ❑ Work phone ❑ Email

In case of emergency please contact:

Name _____

Relationship _____

Home phone (_____) _____

Work/Other phone (_____) _____

Height _____Weight_____

Blood Pressure _____/_____

Medical Allergies_____

Have you smoked ? Yes / No Still Smoke? Yes / No

If YES, Packs per day? _____

Medications Name	Milligrams	Dosage Per Day

INSURANCE

Insurance Carrier_____

Policy Holder Name_____

Date of Birth____/_____/_____

Social Security #_____

Group #_____ID#_____

Referral #_____

Patient Condition

What is you major complaint *(be as specific as possible)* _____

_____

When did your condition/symptoms/pain first appear? *(specific date, days ago, weeks ago, etc)* _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Since the onset of your problem is it: ❑ Getting worse ❑ Staying the same ❑ Slow to improve

When is it worse? ❑ Morning ❑ Afternoon ❑ Evening

Does it interfere with: ❑ Work ❑ Sleep ❑ Daily routines Other _____

How long has it been since you really felt good? _____

Other doctors seen for this condition: ❑ MD ❑ DC ❑ DO ❑ DDS ❑ Other_____

Patient Condition

Does the condition/symptom/pain radiate? ❑ Yes ❑ No

If yes, where and how frequently _____

How long/often does the radiation occur/last? _____

Do you have: ❑ Numbness ❑ Tingling ❑ Weakness

Describe _____

List and mark the severity of your condition/symptoms/pain on the scales below:

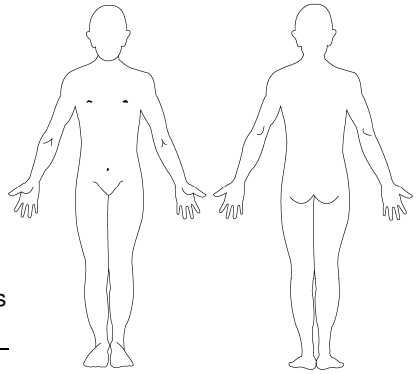
Body part _____ _____

0 (None) 5 (Severe) 10

Body part _____ _____

0 (None) 5 (Severe) 10

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



Type of Pain: ❑ sharp ❑ dull ❑ aching ❑ throbbing ❑ numbness ❑ shooting ❑ burning ❑ tingling ❑ Other _____

What activities or positions aggravate your condition?

❑ bending ❑ coughing ❑ getting up/down ❑ driving ❑ lifting ❑ lying down ❑ reaching ❑ sitting ❑ sneezing ❑ standing ❑ straining at stool ❑ turning head ❑ twisting ❑ walking Other _____

What activities or positions relieve your condition?

❑ heat ❑ ice ❑ lying down ❑ medication ❑ sitting ❑ standing ❑ stretching Other _____

Have you ever had this condition before? ❑ Yes ❑ No If yes, when? _____

Were you treated for this condition or a similar one before? ❑ Yes ❑ No If yes, when/by whom? _____

Health History

Injuries/Surgeries you've had and when? _____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below.***

Ankylosing spondylitis	❑ Yes	❑ No	Cushing's disease	❑ Yes	❑ No	Knee surgery	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Cystic medial necrosis	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Depression	❑ Yes	❑ No	Marfan syndrome	❑ Yes	❑ No
Bleeding disorder	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Multiple sclerosis	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No	Digestive/Bowel problems	❑ Yes	❑ No	Osteoporosis/penia	❑ Yes	❑ No
Bowel/Bladder problems	❑ Yes	❑ No	Dizziness or vertigo	❑ Yes	❑ No	Parkinson's disease	❑ Yes	❑ No
Buzzing in ears	❑ Yes	❑ No	Fibromuscular dysplasia	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Rotator cuff problem	❑ Yes	❑ No
Carpal tunnel	❑ Yes	❑ No	Fusions (spinal, joint, etc)	❑ Yes	❑ No	STI/STD	❑ Yes	❑ No
Celiac disease (gluten)	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Shoulder surgery	❑ Yes	❑ No
Chest pains	❑ Yes	❑ No	Heart disease	❑ Yes	❑ No	Spinal surgery	❑ Yes	❑ No
Chronic fatigue	❑ Yes	❑ No	Hepatitis (A, B, C, etc)	❑ Yes	❑ No	Stroke/TIA	❑ Yes	❑ No
Cold hands or feet	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Thyroid problems	❑ Yes	❑ No
Colitis/Diverticulitis	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Compression fractures	❑ Yes	❑ No	Hip replacement	❑ Yes	❑ No	Other _____		
Connective tissue issues	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Other _____		
COPD (bronchitis/emphy)	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No	Other _____		

Are there any conditions that run in your family? ❑ Yes ❑ No If yes, what condition(s) and which family members? _____

For Women Only

Are you currently pregnant, or do you think you may be pregnant? ❑ Yes ❑ No If yes, for how many weeks? _____

Permission to Test and Treat

I hereby request and consent to the administration of diagnostic procedures, chiropractic adjustments and other chiropractic procedures including, but not limited to, various modes of physical therapy and diagnostic x-rays administered by the staff at Complete Chiropractic & Wellness Center. I have been informed of the benefits and risks of chiropractic care and understand it is my responsibility to ask questions. I attest that the information completed by me on this form is correct and true to the best of my knowledge and agree to notify this office in the event of any change. Payment is expected for all office visits, services, treatments, procedures, and products purchased at the time of each visit unless other arrangements have been made with the business office personnel. I authorize Complete Chiropractic & Wellness Center to bill my insurance comp. for payment on my bill. I agree to pay all charges for medical and health care services not covered by my insurance company.

Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date

Thank you for completing our health care questionnaire