Stevens	Chiro	practic	Center
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Dr. Matthew Stevens

903 Williams Street • Angola, Indiana 46703 • (260) 665-9479

Date       SS#         Name       Email Address         (First)       (MI)         (Last)       Phone#: Cell/Home         Local Address	Patient ID#	CONFIDENTIAL PAT	IENT INFORMAT	
Name       Email Address         (First)       (MI)       (Last)         Phone#: Cell/Home	Data			
(First)       (MI)       (Last)         Phone#: Cell/Home		,		
Phone#: Cell/Home			Email Address	
Local Address       City/State/Zip         Age       DOB         Age       Marital Status: S M W D Number of Children         Occupation       Employer         Work Address       City/State/Zip         Emergency Contact       Relation         Phone #       Phone #         Who may we thank for referring you to our office?       Phone #         Have you had an X-ray or MRI of your spine in the last year?       Yes       No         Have you ever had Chiropractic care before?       If so, when?       If so, when?         List your primary complaints:       (1)       For how long?       City         (1)       For how long?       Specialty:       City       City         (2)       Specialty:       Specialt				
Age DOB/ Marital Status: S M W D       Number of Children         Occupation Employer Work Phone #         Work Address City/State/Zip         Emergency Contact Relation Phone #         Who may we thank for referring you to our office?         Have you had an X-ray or MRI of your spine in the last year? Yes No         Have you ever had Chiropractic care before? If so, when?         List your primary complaints:         (1) For how long?         (2) Specialty:         List any other doctors you have consulted for these conditions:         (1) Specialty:         [1] Specialty:         List any other doctors you have consulted for these conditions:         (1) Specialty:			City/State/Zin	
Occupation Employer Work Phone #         Work Address City/State/Zip         Emergency Contact Relation Phone #         Who may we thank for referring you to our office?         Have you had an X-ray or MRI of your spine in the last year? If so, when?         List your primary complaints:         (1) For how long?				
Work Address	-			
Who may we thank for referring you to our office?     Have you had an X-ray or MRI of your spine in the last year?   If so, when?     List your primary complaints:     (1)   (2)   For how long?     (2)   For how long?   (2)   For how long?   (1)   For how long?   (2)   For how long?   (2)   Did this injury occur while at work?   Have you reported it to your employer?   List major surgeries:   (1)   (1)   (2)   List an injury related to an auto accident?   (2)   When:   (1)   (2)   (1)   (2)   (1)   (2)   (2)   (3)				
Have you had an X-ray or MRI of your spine in the last year? Yes No   Have you ever had Chiropractic care before? If so, when?				
Have you ever had Chiropractic care before? If so, when?   List your primary complaints:   (1) For how long?   (2) For how long?   List any other doctors you have consulted for these conditions:   (1) Specialty:   (2) Specialty:   (2) Specialty:   Did this injury occur while at work? Have you reported it to your employer?   List major surgeries:   (1) When:   (2) When:   List all current medications. If no current medications, check here: □   1)				
List your primary complaints:   (1)For how long?   (2)For how long?   (2)For how long?   List any other doctors you have consulted for these conditions:   (1)Specialty:   (2)Specialty:   (2)Specialty:   (2)Specialty:   (2)Specialty:   (2)Have you reported it to your employer?   Is this an injury related to an auto accident?	Have you had an X-ray or MRI of	your spine in the last year	? $\Box$ Yes $\Box$ No	)
(1)For how long?   (2)For how long?   (2)For how long?   List any other doctors you have consulted for these conditions:     (1)   (2)   (2)   (2)   (2)   (2)   (2)   (2)   (2)   (3)      For how long? For how long? List all current medications. If no current medications, check here: □   (1)   (2)   (3)	Have you ever had Chiropractic can	re before?	If so, when?	
(2) For how long?   List any other doctors you have consulted for these conditions:   (1) Specialty:   (2) Specialty:   (2) Specialty:   (2) Specialty:   (2) Bave you reported it to your employer?   (3) When:   (4) When:   (5) When:   (6) When:   (7) When:   (8) When:   (9) When:   (1) When:   (2) When:   (3)	List your primary complaints:			
List any other doctors you have consulted for these conditions:         (1)	(1)		For how long	?
(1)	(2)		For how long	?
(2) Specialty:         Did this injury occur while at work? Have you reported it to your employer?         Is this an injury related to an auto accident?         List major surgeries:         (1) When:         (2) When:         List all current medications. If no current medications, check here: □         1)2)	List any other doctors you have c	onsulted for these condi	tions:	
(2) Specialty:         Did this injury occur while at work? Have you reported it to your employer?         Is this an injury related to an auto accident?         List major surgeries:         (1) When:         (2) When:         List all current medications. If no current medications, check here: □         1)2)	(1)		Specialty:	
Did this injury occur while at work?       Have you reported it to your employer?         Is this an injury related to an auto accident?       Is this an injury related to an auto accident?         List major surgeries:       (1)       When:         (2)       When:       When:         List all current medications. If no current medications, check here: □       1)				
List major surgeries:         (1)	Did this injury occur while at work	? Have yo	u reported it to your e	employer?
(1)	Is this an injury related to an auto a	ccident?	_	
(2)       When:         List all current medications. If no current medications, check here: □         1)       2)	List major surgeries:			
(2)       When:         List all current medications. If no current medications, check here: □         1)       2)	(1)		When:	
List all current medications. If no current medications, check here:          1)				
	1)	2)	3)	
	4)	5)	6)	

List known allergies you have l	had to any medicat	tions. <u>If no allergies a</u>	re known, check	<u>here</u> : 🗖
1)	2)		3)	
Do you currently use tobacco?	□ Former user	Never been a user	Every Day	• Occasionally
Do you currently use alcohol?	Given Former user	□ Never been a user	□ Every Day	• Occasionally
How would you describe your s	stress level?	Very Stressed 🛛 A I	Little Stressed	No Stress
How would you describe your a	activity level?	Very Active Some	etimes Active	Very Little Activity
		Pleas	se mark your areas	s of pain on the figure below.
05	10			
Circle how bad your pain is: 0	= no pain, 10 $=$ un	bearable		$\bigcirc$
HAVE VOUENED EVDEDIENCE	D ANY OF THE FOL	LOWINC.	A	$(\epsilon \}$
HAVE YOU EVER EXPERIENCE				
Check Current and Cir	cle Past Health Issue	es	( )	
<ul> <li>□ Stroke</li> <li>□ Fatigue</li> <li>□ Nervousness</li> <li>□ Numbness in arms or legs</li> <li>□ Weakness in arms or legs</li> </ul>	<ul> <li>Headaches / M</li> <li>HIV/AIDS</li> <li>Dizziness</li> <li>Cancer</li> <li>Diabetes</li> </ul>	Migraines		
<ul> <li>□ Weakness in arms or legs</li> <li>□ Spinal Curvature</li> <li>□ Heart Disease</li> </ul>	□ Diabetes □ Neck Pain □ Low Back Pai	in	$\left\{ \left\{ \right\} \right\}$	
<ul> <li>Heart Disease</li> <li>High Blood Pressure</li> <li>Heart Attack</li> </ul>	$\Box Depression$ $\Box Anxiety$	***	) ( )	5 °C Julie

LIST any of the above conditions that run in your family:

## LIST all other known health issues:

Gastrointestinal complaints:	□ None	List:
Ear, Nose, Throat complaints:	□ None	List:
Muscle, Joint, Bone complaints:	□ None	List:
Genital, Urinary complaints:	□ None	List:
Cardiovascular complaints:	□ None	List:
Male Related complaints:	□ None	List:
Female Related complaints:	□ None	List:
Other Related complaints:	□ None	List:

## Check method of payment for today's service:

$\Box$ Cash	$\Box$ Check	□ MasterCard	🗆 Visa	□ Care Credit	
Major Med	lical Insuranc	e Co			