Stevens Chiropractic Center Dr. Matthew Stevens

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

Patient ID#_____

CONFIDENTIAL PATIENT INFORMATION

Date_____ SS# _____

Name_____ Email Address_____

(First) (MI) (Last)

Phone#: Cell/Home_____

Local Address_____ City/State/Zip _____

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) _____ For how long? _____

List any other doctors you have consulted for these conditions:

(1) _____ Specialty: _____

(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) _____ 3) _____

4) _____ 5) _____ 6) _____

List known allergies you have had to any medications. <u>If no allergies are known, check here</u>: ❑

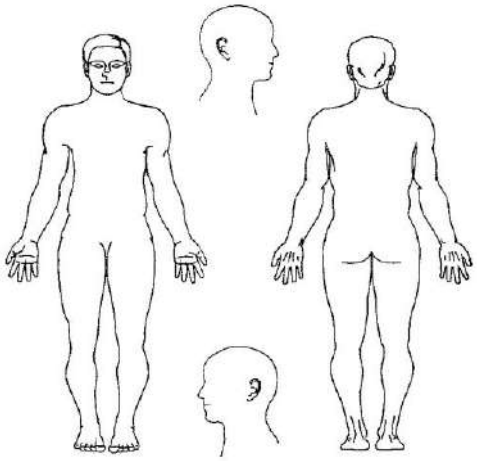
1) _____ 2) _____ 3) _____

Do you currently use tobacco? ❑ Former user ❑ Never been a user ❑ Every Day ❑ Occasionally
Do you currently use alcohol? ❑ Former user ❑ Never been a user ❑ Every Day ❑ Occasionally

How would you describe your stress level? ❑ Very Stressed ❑ A Little Stressed ❑ No Stress
How would you describe your activity level? ❑ Very Active ❑ Sometimes Active ❑ Very Little Activity

Please mark your areas of pain on the figure below.

0----------5----------10
Circle how bad your pain is: 0 = no pain, 10 = unbearable



<u>HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:</u>

<u>Check Current and Circle Past Health Issues</u>

□ Stroke
□ Fatigue
□ Nervousness
□ Numbness in arms or legs
□ Weakness in arms or legs
□ Spinal Curvature
□ Heart Disease
□ High Blood Pressure
□ Heart Attack
□ Headaches / Migraines
□ HIV/AIDS
□ Dizziness
□ Cancer
□ Diabetes
□ Neck Pain
□ Low Back Pain
□ Depression
□ Anxiety

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

<u>LIST all other known health issues</u>:

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:

□ Cash □ Check □ MasterCard □ Visa □ Care Credit

Major Medical Insurance Co. _____