NATURALLY
CHIROPRACTIC

Demographic Information

Patient Information:

First name: _____Middle:_____Last:_____
Sex: *Male / Female* Marital Status: *Married Single Other* Date of Birth:_____/_____/_____
Social Security #_____
Home Address: _____Apt #_____
City: _____ State: _____ Zip: _____
Home Phone: _(_____)_____ Cell: _(_____)_____
Cell phone carrier: _____
Email:_____
Emergency Contact Name & Phone #: _____ Relationship:_____

How did you hear about us? __*Google* __*Provider Directory* __*Personal Referral* __*Internet search*
__*Medical Provider* __*Facebook* __*Other:* _____

Employer Information:

Occupation: _____
Employer: _____ Phone: _____
Business Address: _____

Are you here as a result of an accident: *Yes / No* Date of Accident: _____/_____/_____
Type of Accident: ____Auto ____Sport ____Work _____Slip/Fall Other_____
Attorney *(if any):* _____

Insurance Information:

Primary Insurance: _____ I.D. #_____
Group #: _____

Secondary Insurance *(if any):* _____ I.D. #_____
Group #: _____

Auto Accidents only:
Auto Insurance: _____ Policy ID #: _____
Claim # :_____

MEDICAL HISTORY FORM

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____ (dd/mm/yr)

Date of Birth: _____ ☐ **male** ☐ **female**

Complaint Areas:
1. _____
2. _____
3. _____
4. _____

Have you ever treated with a Chiropractor before? Yes / No

Instructions: Please check mark any current problems. Write "P" for any past problems.

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Congestive heart failure
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps

Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mamogram: _____
☐ normal, ☐ abnormal

- ☐ Abdominal Aortic Aneursym
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer _____
- ☐ Chicken pox
- ☐ COPD
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list ALL medications you are currently taking. If unknown, list why you are taking them.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

☐ I am currently NOT taking any medications

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Have you had this condition before? Yes / No If yes, how many flare-ups have you had in the last year? _____

What seemed to be the initial cause: _____

Have you undergone any Diagnostic Imaging (Xray, MRI, CT, etc..) for this condition in the last year? Yes / No Type:_____

What makes your pain worse? (ie. bending, laying down, work, etc) _____

What makes your pain better? (ie. meds, ice, heat, etc) _____

Please list ALL Hospitals, Urgent Care facilities, Primary's and/or other Medical providers that you have been treated or seen by since THIS episode/incident. □ *I have NOT been anywhere.*

Hospital/ER/Urgent care Name:

1._____ Date/s of Service: _____
2. _____ Date/s of Service: _____
3. _____ Date/s of Service: _____

Medical Provider/Clinic Name:

1. _____ Date/s of Service: _____
2. _____ Date/s of Service: _____
3. _____ Date/s of Service: _____

Chiropractic Clinic/Chiropractor Name:

1. _____ Date/s of Service: _____
2. _____ Date/s of Service: _____

Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 years?	□	□	_____
…had any traumas? (car accident, fall, etc)	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
…had any surgeries? List ALL please.	□	□	_____
			_____
			_____
			_____

When was your last physical exam? _____ Was it Normal / Abnormal?

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

I hereby certify that the above information I have provided is true and accurate to the best of my knowledge.

Patient Signature (Parent or Guardian, if minor): _____ Date: _____/_____/_____

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Pain Scale & Diagram

Name: _____ Date: _____

Primary Area/s of Complaint	Pain Level (circle a number)
1._____	0 1 2 3 4 5 6 7 8 9 10
2._____	0 1 2 3 4 5 6 7 8 9 10
3._____	0 1 2 3 4 5 6 7 8 9 10
4._____	0 1 2 3 4 5 6 7 8 9 10
5._____	0 1 2 3 4 5 6 7 8 9 10
	NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

Quality of Pain: *Use the letters and diagram below to indicate the type **and** location of your sensation right now.*

A=Aching T=Throbbing B=Burning S=Sharp N=Numbness TI=Tingling