

Patient Introduction Card

Today's Date _____

Account # _____

Full Legal Name _____ Prefer To Be Called _____

Home Address _____ Occupation _____

City _____ State _____ Zip _____ Employer _____

Home Phone _____ Name of Insurance Co _____

Cell Phone _____ Policy Holder Name _____

Work Phone _____ Policy Holder Date of Birth _____

Email _____ Primary Care Doctor _____

Date of Birth _____ Age _____ Previous Chiropractic Care? YES NO

Married Single Other _____ Major Complaint Today _____

Preferred method of contact for appointment reminders Text Email Either is fine

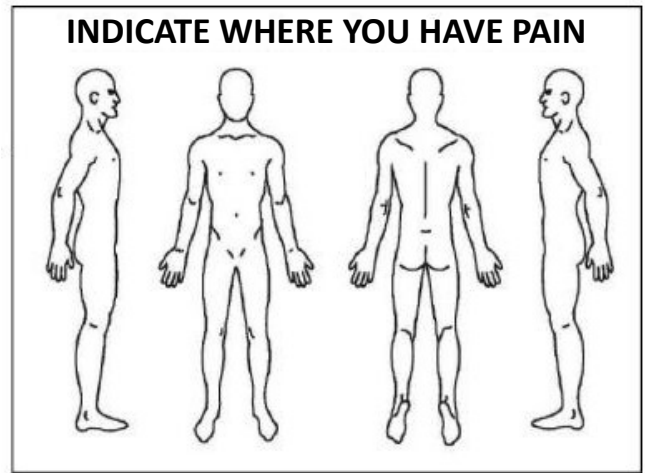
Who (or what source) referred you to our office? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient Health Questionnaire

Patient Name _____ Date _____

1. What are your current symptoms (List the worst one first):



2. How long have you had your main symptom?

This episode: _____

First episode EVER: _____

3. How often are your symptoms present?

- Occasional (0-25%) Frequent (50-75%)
 Intermittent (25-50%) Constant (75-100%)

4. What do you feel caused your symptoms?

- Car Accident Fall Sports Injury Lifting
 Work Posture Other _____

5. What have you tried for your current complaint?

- Nothing Advil / Tylenol / Aleve (CIRCLE) Chiropractic Care Yoga
 Prescription Pain Meds Injections Acupuncture CBD
 Muscle Relaxer Massage Therapy Physical Therapy New Mattress / Pillow (CIRCLE)
 Ice / Heat (CIRCLE) Foam roller Stretching _____

6. Who else have you seen for your current symptoms?

- No One Medical Doctor / PCP Neurologist Acupuncturist
 This Office OBGYN / Midwife Physical Therapist OTHER _____
 Other Chiropractor Orthopedic Doctor Massage Therapist

7. What tests have you had for your symptoms?

- None MRI date: _____
 X-rays date: _____ CT Scan date: _____

8. What activities make your symptoms better?

- Ice Rest Sitting Medication
 Heat Activity Standing _____

9. What activities make your symptoms worse?

- Ice Rest Sitting Medication
 Heat Activity Standing _____

10. What describes the nature of your symptoms?

- Dull Aching Numb Burning Tight / Stiff
 Sharp with movement Shooting Tingling Sore

11. Do your symptoms radiate (travel)? Yes No If yes, to what part of your body? _____

12. What is the severity of your symptoms (CIRCLE the range)? 0 1 2 3 4 5 6 7 8 9 10

13. What activities are affected by your symptoms?

- Work/School (CIRCLE) Exercise Driving/Riding in Car (CIRCLE) House Work Mood
 Getting dressed Running Caring for Children Yard Work Focus
 Sleeping Walking Going up / down stairs Bathing _____

14. Have your symptoms been getting...

- Better Worse Staying the same

Please check any condition below that you had in the past or have currently...

16. 17.

PAST PRESENT

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Scoliosis
- Shoulder Pain
- Elbow Pain
- Wrist Pain
- Hand Pain
- Carpal Tunnel
- Hip Pain
- Knee Pain
- Ankle Pain
- Foot Pain
- Sciatica
- Jaw Pain/TMJ
- Osteopenia
- Osteoporosis
- Joint Swelling/Stiffness
- Arthritis
- Rheumatoid Arthritis
- Lyme Disease
- General Fatigue
- Ringing in Ears
- Visual Disturbances
- Dizziness
- Nausea

PAST PRESENT

- High Blood Pressure
- Low Blood Pressure
- High Cholesterol
- Heart Attack
- Chest Pains
- Stroke
- Angina
- Kidney Stones
- Kidney Disorder
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Reflux/Heartburn
- Abnormal Weight Gain
- Abnormal Weight Loss
- Loss of Appetite
- Constipation
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver Disorder
- Gall Bladder Disorder
- Cancer
- Tumor
- Asthma
- Chronic Sinusitis
- Seasonal Allergies

PAST PRESENT

- Diabetes
- Excessive Thirst
- Excessive Urination
- Hypo-Thyroid
- Hyper-Thyroid
- Smoking/Tobacco Use
- Drug/Opioid Dependence
- Alcohol Dependence
- Food Allergies
- Depression
- Anxiety
- Frequent Illness
- Epilepsy
- Dermatitis
- Eczema
- Poison Ivy/Oak
- HIV/AIDS

Females Only

- Hot Flashes
- Hormone Replacement
- Birth Control Pills
- Painful Periods/Cramps

YES NO Are You Pregnant?

18. Primary Care Physician _____ 18b. Date of Last Medical Physical _____

19. Indicate if an immediate family member has had any of the following:

- Rheumatoid Arthritis
- Heart Problems
- Diabetes
- Cancer
- Lupus
- Other: _____

20. List all prescription and over-the-counter medications, nutritional/herbal supplements, essential oils, or CBD you are taking:

21. List all the surgical procedures you have had AND times you have been hospitalized (INCLUDING GIVING BIRTH):

22. ANY & ALL LIFETIME TRAUMA HISTORY, EVEN IF YOU DID NOT HAVE SYMPTOMS OR TREATMENT:

Auto Accidents: _____

Falls: _____

Sports Injuries: _____

Concussions: _____

Other Physical Traumas: _____

23. Age of Mattress: _____ years Sleep Position: back side stomach # of pillows under your head? _____

PATIENT SIGNATURE: _____ Date: _____