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CHIPLEY CHIROPRACTIC -CONFIDENTIAL PATIENT INFORMATION

	(Middle Initial) (Last)	do you prefer to be called?
Address	City	State Zip
Best Contact Phone	Text Appt Reminder Ok	X? Yes / No
Date of Birth:	Soc Sec #:	Email:
Employer	Occupation	Work Phone
Please Circle One: Marri	ed Single Divorced; If Married, Spous	e's Name:
(Optional) - Plea	ase List Any Other Person who can ha	ve access to YOUR Health Information
		You:
	Pain that Prompted me to seek tr	·
When did it start?		
What makes it worse? _		
Does anything give you	relief?	
What does it feel Like? Radiation:	Ache Sharp Shooting Other:	
Rate your pain from 0 to	o 10 (0 = No Pain & 10 = Emergency	Room Pain):
•	in? Circle one: Constant 3/4 of the day	· ·
	ary complaint, please list it below	
When did it start?		
What does it feel Like?		
Rate your pain from 0 to	o 10 (0 = No Pain & 10 = Emergency	Room ram).

	Back	Heart	Stroke	Cancer	Diabe	etes	High BP	Arthritis	High	esterol	Osteo	porosis	Thyro	id	Good
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Medications: Please list you have a list we c		sage and how often you take it (If None then check box here: opy it for you)
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Activities of	Activities of Daily Living: How Does this condition interfere with your life and ability to function?								pg 4/4
	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting					Caring for Family				
Rising out of Chair					Household Chores				
Standing					Lifting Objects				
Walking					Reaching Overhead				
Lying Down					Showering or Bathing				
Bending over					Dressing Myself				
Climbing stairs					Yard work				
Using a Computer					Getting to Sleep				
Getting in/out of car					Staying Asleep				
Driving a car					Concentrating				
Looking over shoulder					Exercising				
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resp	onsible f he best o	or the pay f my abil	yment of any ity the inform	covered on ation I has	r non-covered servic ve supplied is comple of my health conce	es I receivete and tr	ve.		
Patient (or G	duardian'	s) signatı	ıre		Date (M	M/DD/Y`	Y)		