Patient Information

Name _____ Birth date _____ Age _____
First Middle Last

Address _____ Home Phone _____ Work Phone _____

City _____ State _____ Zip _____ Social Security # _____

Insurance Company _____ Employer's Name _____

Sex [M F] Spouse's Name _____ Occupation _____

Marital status – [M W D S] Email Address _____

Have you had chiropractic care before? _____ When? _____

What is your current complaint? _____

Is this condition due to: [ ] Auto accident [ ] Work injury [ ] Other accident [ ] Illness [ ] Unknown cause

Date symptoms appeared _____ **If Accident, please describe what happened:** _____

_____

_____

What aggravates your condition: [ ] Standing [ ] Twisting [ ] Bending [ ] Sitting [ ] Lying [ ] Walking [ ] Coughing [ ] Lifting

Are your symptoms:
[ ] Improving (101)
[ ] About the same (102)
[ ] Getting Worse (103)
[ ] Intermittent (come and go) (104)

Have you had these symptoms before?
[ ] NO (105)
[ ] YES When? _____

Who is your family doctor? (106)
Dr. _____

List all surgical operations: (107)
_____
_____
_____

List all prescription drugs you now take: (108)
_____
_____
_____
_____
_____

List all non-prescription drugs you now take: (109)
_____
_____
_____
_____

Check here if you have a family history of:
[ ] arthritis (110)
[ ] cardiovascular disease (111)
[ ] diabetes (112)
[ ] cancer (113)

Social Habits: (114) [ ] tobacco [ ] alcohol [ ] coffee
Exercise Activity: (115) [ ] no exercise program [ ] light exercise [ ] moderate exercise [ ] strenuous exercise
Stress levels: (116) [ ] little or no [ ] minimal [ ] moderate [ ] greatly-stressed

Physical Activity: (117) [ ] sitting 50% or more [ ] light labor [ ] manual labor [ ] heavy labor [ ] repeated motion

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU MAY HAVE HAD: (118)

[ ] High Blood Pressure	[ ] Asthma	[ ] Gastric Ulcers	[ ] Joint Pains
[ ] Heart Disease	[ ] Bronchitis	[ ] Colitis/Spastic Colon	[ ] Jaw Pain
[ ] Heart Murmurs	[ ] Pulmonary Disease	[ ] Acid Reflux	[ ] Shoulder Pain
[ ] Diabetes	[ ] Emphysema	[ ] Hiatal Hernia	[ ] Numbness
[ ] Headaches	[ ] Pneumonia	[ ] Gas/Bloating	[ ] Hepatitis A B C
[ ] Sinus/Allergies	[ ] Kidney Stones	[ ] Premenstrual Pains	[ ] HIV+ / AIDS

How did you hear about us? [ ] Friend, Whom? _____ [ ] Other? _____

The above information is true and accurate to the best of my knowledge

Signature _____ Date _____