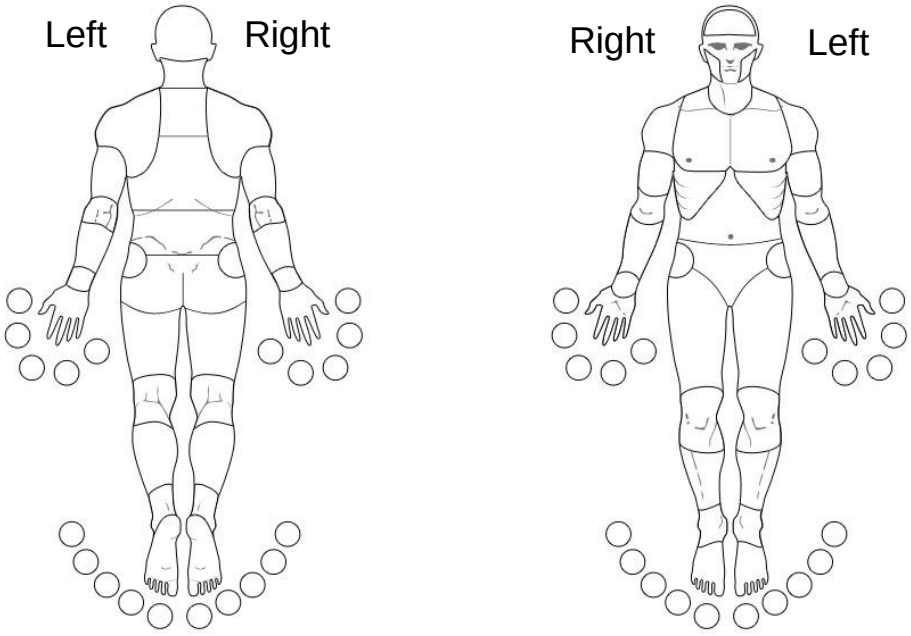
CONFIDENTIAL PATIENT INFORMATION

It is good to see you again! Please don't ever hesitate to come back to our office for care. We find that patients use our services in many ways. Some come in only when they start hurting bad enough. We always keep a revolving door open for those situations. Others know that, just like brushing your teeth regularly, seeing the chiropractor regular keeps you feeling and functioning at your best. We're always here, no matter how you choose to use us!

Name:	Date:
Complete if there has been any change in the following?	
New Phone #:	___ No Change
New Address:	___ No Change
E-mail address:	
Any change in your insurance coverage?	___ No ___Yes (If yes, please advise front desk staff)

WHAT KIND OF PROBLEM(S) ARE YOU HAVING?						
When did this begin?	If you are not sure give us your best estimate >					
HOW WOULD YOU DESCRIBE YOUR SYPMTOMS? (Circle any that apply)	Pain	Ache	Sore	Burning	Kinked	Numbness
	Sharp	Tight	Stabbing	Grabbing	Locked Up	Pins & Needles
	Dull	Stiff	Throbbing	Catching	Spasm	Tingling
	Other:					
RATE YOUR SYMPTOMS (10 is the worst)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**(worst)**
Frequency →	☐ Infrequent < 25%	☐ Occasional 25% to 50%	☐ Frequent 50% to 75%	☐ Constant > 75%							
What makes it better?	☐ Medication	☐ Lying Down	☐ Standing	☐ Sitting	☐ Ice / Heat	☐ Activity	☐ Nothing				
	Other:										
What makes it worse?	Nothing	Lifting	Sleep	Sneeze/Cough	Noise						
	Standing prolonged	Moving wrong	Exercise	Computer work	Stress						
	Sitting prolonged	Slouching	Household work	Neck flexion	Bright lights						
	Other:										

Circle areas where you are currently experiencing symptoms →



WHAT DO YOU THINK IS CAUSING YOUR PROBLEM?						
Is this condition interfering with any of the following: (Circle any that apply)						
WORK	**SLEEP**	**DAILY ROUTINE**	**EXERCISE**	**WALKING**	**STANDING**	**SHOPPING**
Which of the following is true: (check one of the following)						
____ It's getting better slowly		____ It's staying the same		____ It's getting worse as time goes by		
Have you had any other care or tried any remedies for this problem: (If yes, describe below)						

TELL US ABOUT HOW THIS IS AFFECTING YOU

What are your symptoms like at their worst:
Does it restrict any activities that you'd like to be doing (describe activity):
Are you taking medication for this?

This form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any future changes in my medical or insurance status.

Signature _____ Date _____