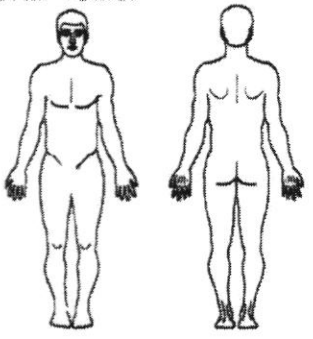
Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

PATIENT DATA SHEET

For Office Use Only: Account #_____ Height_____ Weight _____Blood Pressure_____

Date: _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Email Address: _____

Cell Phone: _____

Would you like alerts for your appointments? Y N Cell or Email

Race: (Please Circle): American Indian Alaska Native Asian

Black or African American Native Hawaiian

White Other Pacific Islander Decline to State

Smoking Status: (Please Circle 1): Current Smoker Never Smoked

Former Smoker: Start Date: _____ End Date: _____

Please list any allergies to medications:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Please all of your current medications:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Any Other Allergies:

_____

_____

_____