AFFINITY CHIROPRACTIC
DR. JANE BIGBY
830 Klamath Ave. ◇ Klamath Falls, OR 97601 ◇ 541-887-8555

Confidential Patient Information

_____/_____/_____
DATE

_____ M ____ F____
NAME

_____/ _____/_____ _____ _____
BIRTHDATE AGE last 4 SSN#

_____ _____ _____
HOME ADDRESS CITY ZIP

_____ _____ _____ _____
HOME PHONE WORK PHONE CELL PHONE E-MAIL

_____
MAILING ADDRESS (if not same)

_____ _____ _____
OCCUPATION EMPLOYER HOW LONG

_____ _____ _____
EMPLOYERS ADDRESS CITY ZIP

Marital Status (circle): Single Married Divorced Separated Widowed _____
SPOUSES NAME (if applicable)

Method of Payment (circle): Cash/Card Ins Medicare Auto Ins Other

How did you learn of our office: yellow pages TV radio Internet Other:_____ referred by: _____

Emergency Information
Who should we contact in case of an emergency? _____

_____ _____ _____
Home Phone Work Phone Cell Phone

Reason For Your Visit
What concern(s) brought you to our office: _____

Is this a documented injury? Y___ N____ If so, what type? Work comp____ Auto Accident___ other:_____

Have you had chiropractic care for this concern? Y____ N____ If yes, results:_____

_____

Other doctors seen for this concern:_____

Health History
What medications are you taking and what are they for?

_____
_____
_____

List any allergies:_____
_____

List previous injuries/ fractures:_____
_____

List previous surgeries/
hospitalizations:_____
_____

Affinity Chiropractic 830 Klamath Ave., Klamath Falls, OR 97601 ph: 541-887-8555 fax: 541-887-8556

Patient's Name:_____ DOB: _____ Date:_____

Family health history:

□ Cancer/tumor □ Diabetes □ High blood pressure
□ Heart problems/ Stroke □ Arthritis

Review of systems: Please indicate if any of the following relate to your health

□ Aneurysm □ Allergies □ Anemia
□ Arteriosclerosis □ Arthritis □ Asthma
□ Back pain □ Bronchitis □ Bruise easily
□ Cancer □ Chest pain □ Cold extremities
□ Concussion □ Constipation □ Cramps
□ Depression □ Diabetes □ Digestion problems
□ Dizziness □ Ears ringing □ Eye pain
□ Fatigue □ Frequent urination □ Headache
□ High blood pressure □ Hot flashes □ Irregular cycle
□ Irregular heart beat □ Kidney infection □ Kidney stones
□ Loss of balance □ Loss of memory □ Loss of smell
□ Loss of taste □ Lumps in breast □ Neck pain or stiffness
□ Nervousness □ Frequent nosebleeds □ Pacemaker
□ Polio □ Poor posture □ Prostrate problems
□ Sciatica □ Shortness of breath □ Sinus infections
□ Sleep problems □ Spinal curvatures □ Stroke
□ Swelling of ankles □ Swollen joints □ Thyroid condition
□ Tuberculosis □ Ulcers □ Varicose veins
□ Other:_____

Tobacco use? No____ Yes_____ Past use? _____ Type & frequency:_____

Do you have children? Y___ N___ If yes, what ages? _____

Women only:

Menstrual cramping/pain (please circle 0 = none, 5 = severe): 0 1 2 3 4 5
Are you pregnant? Y___ N___ If yes, how long? _____
Are you nursing? Y___ N___

<u>All patients:</u>

The above information is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date:_____

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Patient's Name:_____ DOB: _____ Date:_____

Complaint history form

Symptom:_____

- On a scale of 1-10, with 10 being the worst, please circle the number that indicates your pain level for the symptom most of the time? 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the symptom at the above intensity?
  Less than 25% 25-50% 50-75% 75-100%
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (check all that apply)
  □Head or neck movement □Bending/twisting at the waist □Sitting □Standing
  □Getting up from sitting □Lifting □Driving □Walking □Running □Deep breathing □Pushing
  □Pulling □Nothing □Other please describe:
  _____
- What makes the symptom better? (check all that apply)
  □Rest □Ice □Heat □Stretching □Exercise □Massage □Pain medication □Muscle relaxers
  □Nothing □Other: _____
- Describe the quality of the symptom? (check all that apply)
  □Sharp □Dull □Achy □Burning □Numb □Tingling □Throbbing □Stabbing □Deep
  □Shooting □Stinging □Other (please describe): _____
- Does the symptom radiate to another body part? (please circle) Yes No
  - If yes, where does it radiate:_____
- Is the symptom worse at different times of the day or night? (please check all that apply)
  □Morning □Afternoon □Evening □Night □Unaffected by time of day

Symptom:_____

- On a scale of 1-10, with 10 being the worst, please circle the number that indicates your pain level for the symptom most of the time? 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the symptom at the above intensity?
  Less than 25% 25-50% 50-75% 75-100%
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
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  □Pulling □Nothing □Other please describe:
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