motion CHIROPRACTIC
Improve Function, Improve Life.

Confidential Patient Information

Name: _____ **DOB:** _____ **Age:** _____

Social Security Number: _____---_____---_____ (only disclose if you are comfortable or if it is required by your insurance company.)

Address: _____

City/State/Zip: _____

Home phone: _____ **Cell:** _____

Work Phone: _____ **Email address:** _____

Can we send text and/or email reminders? Yes or No

Primary Care Physician: _____ **Phone:** _____

Emergency Contact (name and phone #): _____ **Relationship:** _____

Insurance Company: _____ **Member ID:** _____ **Group #:** _____

How can we help you today?

□ **Chiropractic Care** □ **Nutritional Counseling** □ **Exercise Advice** □ **Lifestyle changes**

How did you hear about us? □ **Insurance Provider List** □ **Google / Internet search** □ **Artisan Apartments / Neighborhood**

□ **Existing Patient (name)** _____ □ **Attorney (name)** _____

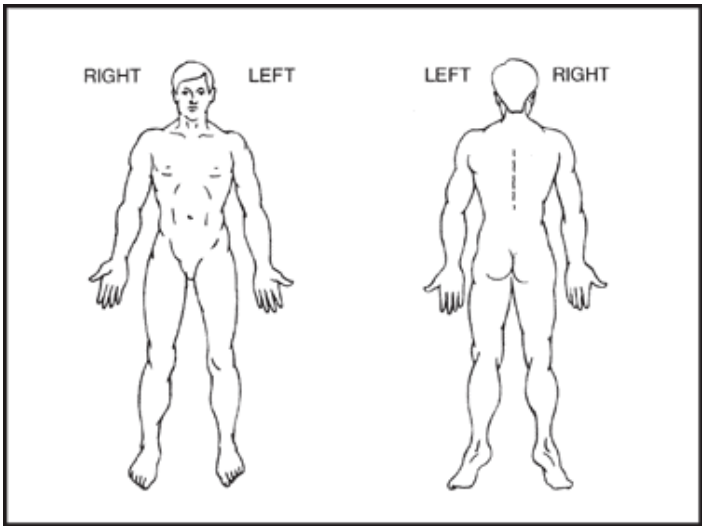
Are you in for a: ☐ **Wellness/Health check-up or a** ☐ **Specific complaint**

How is this condition affecting your everyday life? _____

Have you seen a chiropractor before? _____ **When was the last time?** _____

Did you have a good experience? _____ **What did you like or dislike?** _____

Please indicate on the drawings where you have pain/symptoms:



On a scale from 0-10 (10 being the worst), how would you rate your pain / symptoms?

0 1 2 3 4 5 6 7 8 9 10

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How often do you experience your symptoms?

- ○ Constantly (76-100% of the time)
- ○ Frequently (51-75% of the time)
- ○ Occasionally (26-50% of the time)
- ○ Intermittently (1-25% of the time)

How would you describe your symptoms?

- ○ Sharp
- ○ Dull
- ○ Diffuse
- ○ Achy
- ○ Burning
- ○ Shooting
- ○ Stiff
- ○ Numb
- ○ Tingly
- ○ Sharp with motion
- ○ Shooting with motion
- ○ Stabbing with motion
- ○ Electric-like with motion
- ○ Other _____

How long have you had this problem? _____

How do you think this problem began? _____

What aggravates your problem? _____

What makes it better? _____

How are your symptoms changing over time?

○ Getting worse ○ Staying the same ○ Getting better

What is your: Height _____ **Weight** _____ **Occupation** _____

What activities do you do at work? _____

How would you rate your overall health?

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

Rate your level of exercise activity:

○ Strenuous ○ Moderate ○ Light ○ None

Describe your typical workout routine: _____

Indicate if you or your immediate family members suffer from any of the following

- ○ Rheumatoid Arthritis
- ○ Lupus
- ○ Heart Problems
- ○ ALS
- ○ Diabetes
- ○ Multiple Sclerosis
- ○ Cancer
- ○ Parkinson's
- ○ Any diseases not listed: _____

Do you smoke? _____ **If yes, how many per day?** _____
Do you drink alcohol? _____ **If yes, how many per day?** _____
Do you drink caffeine? _____ **If yes, how much per day?** _____

Please list all prescription and over-the-counter medications you are currently taking: _____

_____

_____

_____

Please list all nutritional supplements you are currently taking: _____

_____

_____

_____

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For the conditions listed below, please check the "past" column if you have had the condition in the past; if you presently have a condition listed below, please check the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss	□	□	Dizziness (with, w/o motion)
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	□	□	General Fatigue
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Joint Pain/Stiffness
□	□	Ulcer	□	□	Arthritis	□	□	Hepatitis
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder	□	□	Cancer
□	□	Tumor	□	□	Muscular Inco-ordination	□	□	Asthma
□	□	Visual Disturbances	□	□	Chronic Sinusitis			
For Women only:								
□	□	Birth Control Pills	□	□	Hormonal Replacement	□	□	Pregnancy
□	□	Abnormal menstrual cycle						

Please list all surgical procedures you have undergone: _____

_____

_____

Have you ever been hospitalized? _____ **If yes, why?** _____

_____

Have you had significant past trauma including, but not limited to, car accidents? ☐ **Yes** ☐ **No**

If yes, what and when? _____

_____

What activities/hobbies do you enjoy outside of work? _____

_____

Is there anything else you wish to let the doctor know about today? _____

_____

_____

Patient signature: _____ **Date:** _____

Thank you for taking the time to answer these questions as completely as possible, it will help us determine the best treatment plan for your individual needs.