FAYETTEVILLE FAMILY CHIROPRACTIC

PLEASE FILL OUT COMPLETELY

Check in PIN #: _____
(6 digits)

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. Rank_____ Other_____

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____

Address 1 _____

Address 2 _____**City** _____

State _____ **Zip Code** _____ **Employer:** _____

Primary Phone: _____ **SSN:** _____

Secondary Phone: _____ **Mobile Phone:** _____

Home Email: _____ **Work Email:** _____
By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

How were you referred to our office? _____

Your Date of Birth ____/____/____ **Age** ____ **Gender** *(check on* ❑ Male ❑ Female ❑ Other

Spouse's Name _____ **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Spouse's Date of Birth _____ **Primary Care Providers Name**

_____

Race *(check one)* ❑ White ❑ Black/African American ❑ Hispanic ❑ Asian ❑ Other _____ ❑ I choose not to specify

I authorize _____ **to receive any medical or billing information in my account.**
Signature required at the bottom of this form for this authorization to be valid.

Have you had previous Chiropractic care? ❑ Yes ❑ No
If yes, when was your last visit and where? _____

Have you had an X-ray, CT scan, or MRI of your back or neck in the past 12 months? ❑ Yes ❑ No

What activity do you enjoy that has become difficult due to this problem? _____

Other doctors seen for this problem (please list): Chiropractor: _____

Medical Doctor: _____**Other:** _____

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELL-BEING

_____ I am only concerned about relief of a particular symptom.
_____ I am only concerned about relief of a particular symptom and preventing its return.
_____ I want optimum health and well-being on every level available to me

Today's Date ____/____/____ **Signature of Patient** _____

Briefly list your main chief complaint _____

When did this problem start? _____ **Have you had this problem before?** _____

Problem is due to: ❑Auto accident ❑Injury ❑Work related ❑Long-term problem ❑Other_____

Intensity of current symptoms? (better) ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 (worst)

Duration and Timing of pain? ❑ Off & On ❑ Frequent ❑ Intermittent ❑Constant ❑Random ❑Recurring

What is most affected? = ❑Employment ❑Homemaking ❑Personal Care ❑Sitting ❑Sleeping ❑Lifting

Quality of Symptoms
(What does it feel like?)
- ❑ Achy
- ❑ Annoying
- ❑ Burning
- ❑ Deep
- ❑ Dull
- ❑ Heavy
- ❑ Intolerable
- ❑ Pulling
- ❑ Sharp
- ❑ Shock like
- ❑ Stabbing
- ❑ Stiffness
- ❑ Throbbing
- ❑ Tightness
- ❑ Tingling
- ❑ Other_____

Relieving Factors (What makes it better?)
- ❑ Chiropractic
- ❑ Heat
- ❑ Ice
- ❑ Exercise
- ❑ Support
- ❑ Massage
- ❑ Nothing
- ❑ OTC medication
- ❑ Rx medication
- ❑ Physical therapy
- ❑ Rest
- ❑ Stretching
- ❑ Work
- ❑ Other_____

Aggravating Factors (What makes it worse?)
- ❑ Any movement
- ❑ Bathing
- ❑ Bending
- ❑ Caring for family
- ❑ Carrying objects
- ❑ Climbing stairs
- ❑ Computer use
- ❑ Concentrating
- ❑ Coughing/sneezing
- ❑ Daily child/pet care
- ❑ Dressing self
- ❑Driving
- ❑ Eating
- ❑ Exercises
- ❑ Falling/staying asleep
- ❑ Getting in/out of car
- ❑ Getting up from lying down
- ❑ Grocery shopping
- ❑ Getting up from sitting
- ❑ Household chores
- ❑ Lifting
- ❑ Looking over shoulder
- ❑ Lying down
- ❑ Pushing
- ❑ Pulling
- ❑ Reaching
- ❑ Reading
- ❑ Resting
- ❑ Running
- ❑ Sitting
- ❑ Squatting
- ❑ Standing
- ❑ Stress
- ❑ Stretching
- ❑ Talking on the phone
- ❑ Turning
- ❑ Twisting
- ❑ Walking
- ❑ Working
- ❑ Yard work
- ❑ Other_____

Illnesses: Check the illnesses you have
Had in the past or **Have** now.

Had	Have	
❑	❑	Diabetes Type1__Type II___
❑	❑	Stroke
❑	❑	Other: _____

Injuries: Have you ever…
- ❑ Had a fractured or broken bone. Date_____
- ❑ Had a spine or nerve disorder. Date _____
- ❑ Been knocked unconscious. Date _____
- ❑ Been injured in an accident. Date _____
- ❑ Used neck or back bracing. Date _____

Family History: Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age	Illnesses	Age of death	Cause of death
Mother				
Father				
Sister				
Brother				
Children				
Children				
Children				

Current Medications (Rx & OTC)	What medication is treating	Frequency & Dosage	Start date

Initial: _____ Date: _____

Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.

Please put a check (☑) beside any condition that you've Had or currently Have.

Musculoskeletal

Had	Have	
❑	❑	Osteoporosis
❑	❑	Knee Injuries
❑	❑	Arthritis
❑	❑	Foot/ankle pain
❑	❑	Scoliosis
❑	❑	Shoulder problems
❑	❑	Neck Pain
❑	❑	Elbow/ wrist pain
❑	❑	Back problems
❑	❑	TMJ issues
❑	❑	Hip disorders
❑	❑	Cramping
❑	❑	Poor posture
❑	❑	Swelling/deformity of joints

Neurological

Had	Have	
❑	❑	Anxiety/ Panic
❑	❑	Depression
❑	❑	Headache/ Migraines
❑	❑	Dizziness
❑	❑	Pins and Needles
❑	❑	Numbness
❑	❑	Epilepsy/ seizures
❑	❑	Memory issues
❑	❑	Stroke
❑	❑	Weak muscles
❑	❑	Temporary loss of: Vision, smell, or hearing

Cardiovascular

Had	Have	
❑	❑	Blood clots
❑	❑	Chest pain/ tightness
❑	❑	Coronary artery disease
❑	❑	Heart attack
❑	❑	High blood pressure
❑	❑	High cholesterol
❑	❑	Leg pain upon walking
❑	❑	Low Blood Pressure
❑	❑	Lower extremity edema
❑	❑	Palpitations

Digestive

Had	Have	
❑	❑	Abdominal pain
❑	❑	Black/ bloody stool
❑	❑	Changes in bowel habits
❑	❑	Colon cancer or polyps
❑	❑	Constipation
❑	❑	Gastric reflux
❑	❑	Heartburn
❑	❑	IBS
❑	❑	Liver disease
❑	❑	Nausea/ vomiting
❑	❑	Diarrhea
❑	❑	Ulcer

Dermatological

Had	Have	
❑	❑	Psoriasis
❑	❑	Eczema
❑	❑	Excessive hair loss
❑	❑	Skin cancer
❑	❑	Skin trouble/ rashes
❑	❑	Change in hair/ nails

Respiratory

Had	Have	
❑	❑	Asthma
❑	❑	Emphysema
❑	❑	Shortness of Breath
❑	❑	Persistent cough
❑	❑	Wheezing
❑	❑	Breathing Difficulties

Endocrine

Had	Have	
❑	❑	Excessive thirst
❑	❑	Testosterone deficiency
❑	❑	Thyroid problems

Genitourinary

Had	Have	
❑	❑	Blood in the urine
❑	❑	Incontinence
❑	❑	Kidney stones
❑	❑	Urgency
❑	❑	Painful/frequent urination

Surgeries, which may or may not have included hospitalization and **Dates**

- ❑ Bypass surgery _____
- ❑ Cancer _____
- ❑ Elective surgery _____
- ❑ Hysterectomy _____
- ❑ Pacemaker_____
- ❑ Spine_____
- ❑ Wisdom teeth_____
- ❑ Other: _____

Head and ENT

Had	Have	
❑	❑	Blurred/ double vision
❑	❑	Difficulty swallowing
❑	❑	Ear/ hearing problems
❑	❑	Sinus Trouble
❑	❑	Ringing in the ears
❑	❑	Swollen lymph nodes

Social History Tell us about your health habits and stress levels. Please write **N/A** if it doesn't apply to you.

Employment Status: Occupation _____ Hours per week _____ Change due to current problem _____

Do you smoke? ____ Yes ____No How long? _____ Packs a day? ____
How long since you stopped smoking? _____

How interested are you in quitting? - Please Circle: No 1 2 3 4 5 6 7 8 9 10 Yes

Alcohol use -- ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Alcoholic ❑ Recovering alcoholic

Recreational Drug use -- ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Drug addicted ❑ Recovering drug addict

Caffeine use -- ❑ None ❑ 1cup/day ❑2-4cups/day ❑ 5+cups/day

Exercise habits -- ❑ None ❑ Daily ❑ 2-3 times a week ❑ Weekly ❑ Occasionally **Type**? _____

Is your diet restricted? _____ Any recent change in diet?_____

Any Change in social habits due to current issue?_____

Initial: _____ Date: _____