FAYETTEVILLE FAMILY CHIROPRACTIC

PLEASE FILL OUT COMPLETELY - PEDS

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

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

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

City _____ **State** _____ **Zip Code**_____

Guardian's Name (if under 18) _____ **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**.*

Contact Method *(check one)* ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Would you like us to TEXT message you? *(Check one)* ❑YES ❑ NO **Cell Phone Provider:** _____

Who referred you to our office? _____

Your Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female

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

Insurance Carrier _____ **Policy Number** _____

Primary Care Providers Name _____ **Insured's Name** _____

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

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Other _____ ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet?
❑ What is your favorite movie?
❑ What was the make of your first car?
❑ In what city were you born?
❑ What is your mother's maiden name?
❑ When is your anniversary?
❑ What high school did you attend?
❑ On what street did you grow up?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

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? _____

Fayetteville Family Chiropractic _____ Patient Health History

PRINT YOUR NAME AND DATE HERE

Briefly list your main health problem_____

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? ❑ 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 ❑Standing ❑Social life ❑Traveling ❑Walking ❑Other _____

Due to this problem what is difficult?

❑ Bending Over	❑ Driving Car	❑ Household chores	❑ Showering/bathing	❑ Walking
❑ Climbing Stairs	❑ Exercising	❑ Lifting objects	❑ Sitting	❑ Yard work
❑ Caring for family	❑ Getting in/out of car	❑ Looking over shoulder	❑ Standing	❑ Other_____
❑ Concentrating	❑ Getting to sleep	❑ Lying down	❑ Staying asleep	
❑ Dressing self	❑ Grocery shopping	❑ Raising out of chair or bed	❑ Using a computer	

Type of Delivery: VAGINAL C-SECTION
Pain Medication during delivery: EPIDURAL NONE
Did they use: FORCEPTS VACUUM OTHER

How long was your labor? _____ Hours
How long were you pushing? _____ Minutes

Single or Multiple births

Weight: _____ Length: _____

APGAR score (1 - 10) _____

Gestational Age (weeks) _____

Vaccinated? All on Schedule
On a Delayed Schedule
Not Vaccinated
For only: _____

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 _____

Quality of Symptoms
(What does it feel like?)
- ❑ Achy
- ❑ Annoying
- ❑ Burning
- ❑ Deep
- ❑ Diffuse
- ❑ 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
- ❑ Driving
- ❑ Eating
- ❑ 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_____

What else should the doctor know about your current condition?_____

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

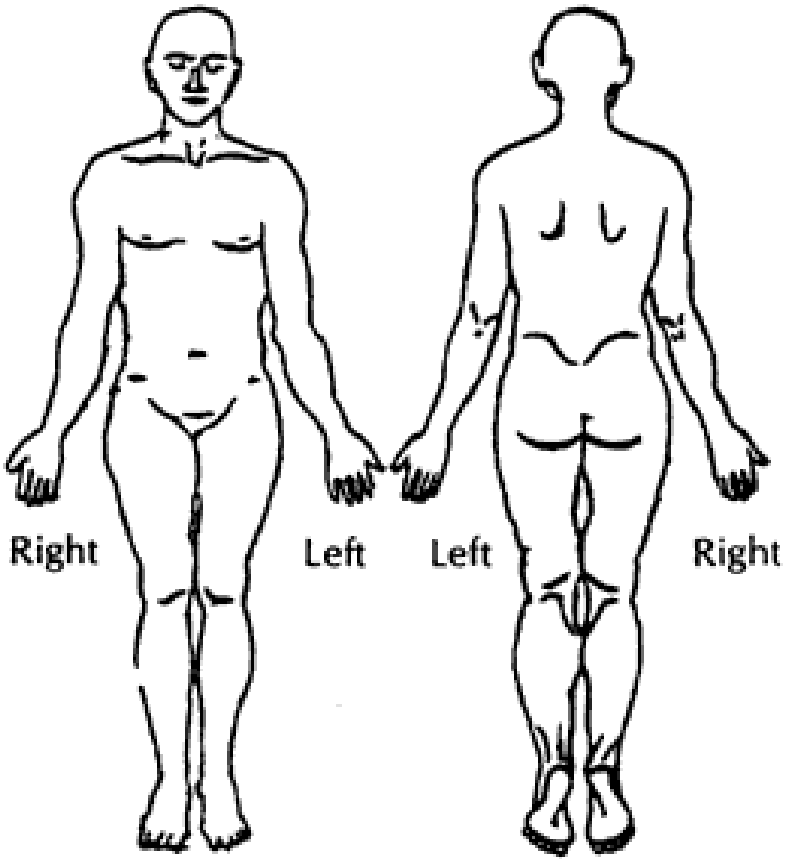
Symptoms

Had	Have	
❑	❑	Acid Reflux
❑	❑	ADD
❑	❑	ADHD
❑	❑	Asperger's
❑	❑	Autism
❑	❑	Autism
❑	❑	Cerebral Palsy
❑	❑	Colic
❑	❑	Congenital Anomalies
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Difficulty Eating
❑	❑	Difficulty Walking
❑	❑	Down's Syndrome
❑	❑	Ear Infections (chronic)
❑	❑	Enuresis
❑	❑	Epilepsy
❑	❑	Febrile Convulsions
❑	❑	Fevers
❑	❑	Foot Flare
❑	❑	Headaches
❑	❑	Inability to Thrive
❑	❑	Jaundice
❑	❑	Seizures
❑	❑	Sleeping Problems
❑	❑	Speech Difficulties
❑	❑	Torticollis

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

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

Location of pain -Circle areas where it hurts



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				
Sister1				
Sister2				
Brother1				
Brother2				

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