PATIENT INFORMATION

Full Name: _____ Date _____/_____/_____

Address: _____City: _____State: _____Zip: _____

Sex: ☐ Male ☐ Female Age: ____ Date of Birth: _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Driver License #: _____
(HIPAA requires us to obtain a copy of your driver's license)

Occupation: _____ ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

Employer: _____ Length of Employment: _____

Spouse's Name: _____ Occupation: _____

Employer: _____ Length of Employment: _____

Children's names & DOBs: _____

Whom may we thank for referring you? _____

CONTACT INFORMATION

Home: _____ Cell: _____ Work: _____ Ext: _____ Text-Message Enabled? ☐ Yes ☐ No

What is the best time and place to reach you? _____ I would like to receive appointment

E-mail Address: _____ reminders via: **TEXT** or **EMAIL**?

IN CASE OF EMERGENCY, CONTACT: **Cell Provider: _____**

Name: _____ Relationship: _____

Home: _____ Work: _____ Ext: _____ Cell: _____

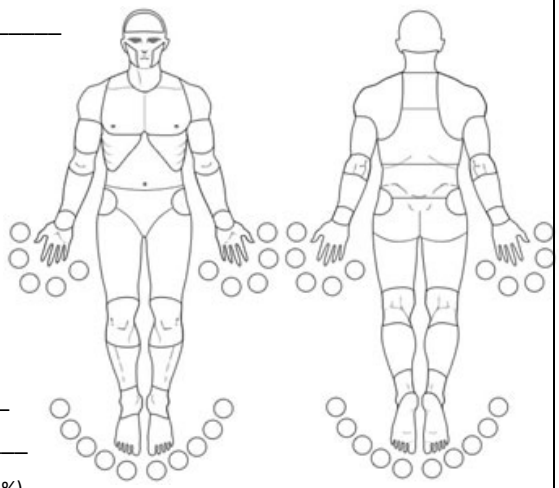
PATIENT CONDITION

Area of Primary Complaint: _____

When did your symptoms first appear? _____

How did your symptoms start? _____

_____



Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Not sure/no change

Pain Rating: (mark circles)

Currently:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
Average:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
At Best :	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
At Worst:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain

Do the symptoms radiate to any other body parts? _____

Described as? ☐ Aching ☐ Burning ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Other: _____

Frequency? ☐ Infrequent (<25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (>75%)

These Symptoms have interfered with my Activities of Daily Living? ☐ Extremely ☐ Quite a Bit ☐ Moderately ☐ A Little Bit ☐ Not at All

Time of day at worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night *and/or* **After Activity:** ☐ Normal ☐ Light ☐ Moderate ☐ Heavy

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ House Work ☐ Driving ☐ Other: _____

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other: _____

What makes it better? ☐Medication ☐ Lying Down ☐Standing ☐Sitting ☐Stretching ☐ Ice ☐ Heat ☐ Sleep ☐ Nothing ☐ Other: _____

What makes it worse?

☐ Movements	☐ Sneezing	☐ Yawning	☐ Lifting	☐ Working
☐ Bending	☐ Sitting	☐ Opening Mouth	☐ Bright Lights	☐ Driving
☐ Twisting	☐ Standing	☐ Closing Mouth	☐ Loud Noises	☐ Housework
☐ Weight Bearing	☐ Walking	☐ Range of Motion	☐ Watching TV	☐ Other: _____
☐ Neck Flexion	☐ Chewing	☐ Pushing/Pulling	☐ Reading	☐ Other: _____

Comments:

HEALTH HISTORY

Present Illness/Conditions: (mark all that apply)

☐ Scoliosis	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Disc Disease	☐ Ulcer
☐ Allergies	☐ Diabetes	☐ Dislocated Joints	☐ Pacemaker	☐ Thyroid Trouble	☐ Polio
☐ Anemia	☐ Diverticulitis	☐ Cirrhosis/Hepatitis	☐ Prostate Trouble	☐ Tuberculosis (TB)	☐ STDs
☐ Arthritis	☐ Low Blood Pressure	☐ Kidney Trouble	☐ Rheumatic Fever	☐ Hay Fever	☐ AIDS
☐ Asthma	☐ High Blood Pressure	☐ Mental Disorder	☐ Sinus Trouble	☐ Bone Fracture	☐ HIV/ARC

Other:

Family History of Illness/Conditions: (mark all that apply)

☐ Scoliosis	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Disc Disease	☐ Ulcer
☐ Allergies	☐ Diabetes	☐ Dislocated Joints	☐ Pacemaker	☐ Thyroid Trouble	☐ Polio
☐ Anemia	☐ Diverticulitis	☐ Cirrhosis/Hepatitis	☐ Prostate Trouble	☐ Tuberculosis (TB)	☐ STDs
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☐ Asthma	☐ High Blood Pressure	☐ Mental Disorder	☐ Sinus Trouble	☐ Bone Fracture	☐ HIV/ARC

Other:

Past Injuries/Surgeries: **Description** **Date**

Auto Accidents ☐Yes ☐No _____ _____/_____/_____

Slips/Falls ☐Yes ☐No _____ _____/_____/_____

Broken Bones ☐Yes ☐No _____ _____/_____/_____

Surgeries ☐Yes ☐No _____ _____/_____/_____

Previous Chiropractic Physician/Location: _____ Last Seen: _____

Current Medical Physician/Location: _____ __ Last Seen: _____

Other medical providers consulted for this condition: _____

Facility and Date of last: X-RAY_____ _____/_____/_____

MRI _____ _____/_____/_____

CT/BONE SCAN _____ _____/_____/_____

Family History of back problems? ☐NO ☐YES, explain: _____

Check any treatments you have tried in treating this condition: ☐ Ice ☐ Dry Heat ☐ Moist Heat ☐ Stretching ☐ Massage

☐ Physical Therapy ☐ Bed Rest ☐ Medications ☐ Other: _____

Results from treatments: _____

List any medications you are currently taking: _____

Sleeping Habits: Position: ☐ Back ☐ Stomach ☐ Left Side ☐ Right Side

Bed Type: ☐ Conventional ☐ Water ☐ Tempurpedic ☐ Air Pillows at head? ⓪ ① ② ③ At Knees? ⓪ ① ② ③ Body Pillow? ☐YES ☐NO

Activities you enjoy when healthy: ☐ Stretch ☐ Jog ☐ Walk ☐ Elliptical ☐ Weights ☐ Tennis ☐ Bowl ☐ Golf ☐ Other: _____

SOCIAL HISTORY

EXERCISE ☐YES ☐NO	**WORK ACTIVITY**	**HABITS**	
☐ Light	☐ Sitting ☐ Computer Work	☐ Smoking	Packs/Day: _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week: _____
☐ Heavy	☐ Light Labor	☐ Coffee/Caffeine Drinks	Drinks/Day: _____
Hours/week: _____	☐ Heavy Labor	☐ High Stress Level	Reason: _____

WOMEN: Date of last menses: _____/_____/_____ Number of days in cycle: _____ Are you pregnant? ☐ Yes ☐ No ☐ Unsure

All questions contained in this questionnaire are STRICTLY CONFIDENTIAL and will become part of your medical record at our office.