Patient Information

Today's Date_____/_____/_____

First Name_____ Middle_____ Last Name_____

Preferred Name_____ Gender: Male / Female Height_____ Weight_____

Date of Birth_____/_____/_____ Age_____ Do you have Medicare? Yes / No

Address_____

City_____State_____Zip_____

H. Phone(_____)_____Cell (_____)_____ Text OK? Yes / No (Mobile provider:_____)

Email_____ Do you prefer email or text reminders? Email / Text

How did you hear about us?_____ May we thank the person who referred you? Yes / No

Marital Status_____ Spouse_____

Contact Person_____ Contact's Phone (_____)_____

Occupation_____ Employer_____

Primary reasons for seeking chiropractic care?

Primary reason: _____

Secondary reason: _____

History of Present Complaint

Chief Complaint: _____

_____

Location of Complaint: _____

Complaint began when and how? _____

_____

Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain/complaint) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present? (constant, daily, weekly, monthly)_____

What percent of awake time is complaint/pain present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

Do you have additional chief complaints? Please describe.

1._____

2._____

3._____

4._____

Review of Symptoms		
General	**Respiratory**	**Low back**
□ Fatigue	□ Asthma	□ Low Back pain
□ Brain Fog	**Cardiovascular**	□ Low Back stiff/tight
□ Weakness	□ High Blood Pressure	□ Hip pain R/L
□ Trouble Sleeping	□ Palpitations	□ Hip stiff/tight R/L
3 Nerves into Head	**Mid-Back**	□ Knee pain R/L
□ Headaches	□ Mid-Back pain	□ Sciatica
□ Migraines	□ Mid-Back stiff/tight	□ Leg pain R/L
□ Dizziness	□ Shoulder pain R/L	□ Pins/needles in legs/feet
□ Ringing in ears	□ Shoulder stiff/tight R/L	□ Numbness in legs/feet
□ Allergies	**Gastrointestinal**	**Neurologic**
□ Sinus Problems	□ Swallowing difficulties	□ Fainting
□ Eye Problems	□ Heartburn	□ Seizures
□ TMJ pain/clicking/popping	□ Constipation	□ Weakness
Neck	□ Diarrhea	□ Tremor
□ Whiplash	□ Irritable Bowel Syndrome	**Psychiatric**
□ Neck pain	□ Colitis	□ Nervousness
□ Neck stiff/tight		□ Stress
□ Traveling pain into arms/hands		□ Depression
		□ Memory loss
□ Pins/needles in arms/hands		
□ Numbness in arms/hands		

Past Health History

Previous illnesses you've had in your life: _____

_____

_____

Previous injury or trauma (especially to the head or neck): _____

_____

_____

Have you ever broken any bones? Which? When?_____

_____

Have you ever been unconscious? Please describe_____

Allergies _____

Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome (natural, C-section, complications, etc…)
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

Family Health History:

Associated health problems of relatives: _____

_____

_____

Social and Occupational History:

Level of Education:

___ high school ___ some college ___ college graduate ___ post graduate studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, caffeine, alcohol, tobacco and drug use, diet):_____

_____

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Doctor Signature _____ Date _____

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1._____

2._____

3._____

4._____

Review of Symptoms		
General	**Respiratory**	**Low back**
□ Fatigue	□ Asthma	□ Low Back pain
□ Brain Fog	**Cardiovascular**	□ Low Back stiff/tight
□ Weakness	□ High Blood Pressure	□ Hip pain R/L
□ Trouble Sleeping	□ Palpitations	□ Hip stiff/tight R/L
3 Nerves into Head	**Mid-Back**	□ Knee pain R/L
□ Headaches	□ Mid-Back pain	□ Sciatica
□ Migraines	□ Mid-Back stiff/tight	□ Leg pain R/L
□ Dizziness	□ Shoulder pain R/L	□ Pins/needles in legs/feet
□ Ringing in ears	□ Shoulder stiff/tight R/L	□ Numbness in legs/feet
□ Allergies	**Gastrointestinal**	**Neurologic**
□ Sinus Problems	□ Swallowing difficulties	□ Fainting
□ Eye Problems	□ Heartburn	□ Seizures
□ TMJ pain/clicking/popping	□ Constipation	□ Weakness
Neck	□ Diarrhea	□ Tremor
□ Whiplash	□ Irritable Bowel Syndrome	**Psychiatric**
□ Neck pain	□ Colitis	□ Nervousness
□ Neck stiff/tight		□ Stress
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Allergies _____

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_____	_____
_____	_____

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2._____

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4._____

Review of Symptoms		
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□ Fatigue	□ Asthma	□ Low Back pain
□ Brain Fog	**Cardiovascular**	□ Low Back stiff/tight
□ Weakness	□ High Blood Pressure	□ Hip pain R/L
□ Trouble Sleeping	□ Palpitations	□ Hip stiff/tight R/L
3 Nerves into Head	**Mid-Back**	□ Knee pain R/L
□ Headaches	□ Mid-Back pain	□ Sciatica
□ Migraines	□ Mid-Back stiff/tight	□ Leg pain R/L
□ Dizziness	□ Shoulder pain R/L	□ Pins/needles in legs/feet
□ Ringing in ears	□ Shoulder stiff/tight R/L	□ Numbness in legs/feet
□ Allergies	**Gastrointestinal**	**Neurologic**
□ Sinus Problems	□ Swallowing difficulties	□ Fainting
□ Eye Problems	□ Heartburn	□ Seizures
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Neck	□ Diarrhea	□ Tremor
□ Whiplash	□ Irritable Bowel Syndrome	**Psychiatric**
□ Neck pain	□ Colitis	□ Nervousness
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Allergies _____

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_____	_____
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_____	_____
_____	_____

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_____	_____
_____	_____
_____	_____

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Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain/complaint) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present? (constant, daily, weekly, monthly)_____

What percent of awake time is complaint/pain present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

Do you have additional chief complaints? Please describe.

1._____

2._____

3._____

4._____

Review of Symptoms		
General	**Respiratory**	**Low back**
□ Fatigue	□ Asthma	□ Low Back pain
□ Brain Fog	**Cardiovascular**	□ Low Back stiff/tight
□ Weakness	□ High Blood Pressure	□ Hip pain R/L
□ Trouble Sleeping	□ Palpitations	□ Hip stiff/tight R/L
3 Nerves into Head	**Mid-Back**	□ Knee pain R/L
□ Headaches	□ Mid-Back pain	□ Sciatica
□ Migraines	□ Mid-Back stiff/tight	□ Leg pain R/L
□ Dizziness	□ Shoulder pain R/L	□ Pins/needles in legs/feet
□ Ringing in ears	□ Shoulder stiff/tight R/L	□ Numbness in legs/feet
□ Allergies	**Gastrointestinal**	**Neurologic**
□ Sinus Problems	□ Swallowing difficulties	□ Fainting
□ Eye Problems	□ Heartburn	□ Seizures
□ TMJ pain/clicking/popping	□ Constipation	□ Weakness
Neck	□ Diarrhea	□ Tremor
□ Whiplash	□ Irritable Bowel Syndrome	**Psychiatric**
□ Neck pain	□ Colitis	□ Nervousness
□ Neck stiff/tight		□ Stress
□ Traveling pain into arms/hands		□ Depression
		□ Memory loss
□ Pins/needles in arms/hands		
□ Numbness in arms/hands		

Past Health History

Previous illnesses you've had in your life: _____

_____

_____

Previous injury or trauma (especially to the head or neck): _____

_____

_____

Have you ever broken any bones? Which? When?_____

_____

Have you ever been unconscious? Please describe_____

Allergies _____

Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome (natural, C-section, complications, etc…)
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

Family Health History:

Associated health problems of relatives: _____

_____

_____

Social and Occupational History:

Level of Education:

___ high school ___ some college ___ college graduate ___ post graduate studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, caffeine, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

Patient Information

Today's Date_____/_____/_____

First Name_____ Middle_____ Last Name_____

Preferred Name_____ Gender: Male / Female Height_____ Weight_____

Date of Birth_____/_____/_____ Age_____ Do you have Medicare? Yes / No

Address_____

City_____State_____Zip_____

H. Phone(_____)_____Cell (_____)_____ Text OK? Yes / No (Mobile provider:_____)

Email_____ Do you prefer email or text reminders? Email / Text

How did you hear about us?_____ May we thank the person who referred you? Yes / No

Marital Status_____ Spouse_____

Contact Person_____ Contact's Phone (_____)_____

Occupation_____ Employer_____

Primary reasons for seeking chiropractic care?

Primary reason: _____

Secondary reason: _____

History of Present Complaint

Chief Complaint: _____

_____

Location of Complaint: _____

Complaint began when and how? _____

_____

Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

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_____

Do you have additional chief complaints? Please describe.

1._____

2._____

3._____

4._____

Review of Symptoms		
General	**Respiratory**	**Low back**
□ Fatigue	□ Asthma	□ Low Back pain
□ Brain Fog	**Cardiovascular**	□ Low Back stiff/tight
□ Weakness	□ High Blood Pressure	□ Hip pain R/L
□ Trouble Sleeping	□ Palpitations	□ Hip stiff/tight R/L
3 Nerves into Head	**Mid-Back**	□ Knee pain R/L
□ Headaches	□ Mid-Back pain	□ Sciatica
□ Migraines	□ Mid-Back stiff/tight	□ Leg pain R/L
□ Dizziness	□ Shoulder pain R/L	□ Pins/needles in legs/feet
□ Ringing in ears	□ Shoulder stiff/tight R/L	□ Numbness in legs/feet
□ Allergies	**Gastrointestinal**	**Neurologic**
□ Sinus Problems	□ Swallowing difficulties	□ Fainting
□ Eye Problems	□ Heartburn	□ Seizures
□ TMJ pain/clicking/popping	□ Constipation	□ Weakness
Neck	□ Diarrhea	□ Tremor
□ Whiplash	□ Irritable Bowel Syndrome	**Psychiatric**
□ Neck pain	□ Colitis	□ Nervousness
□ Neck stiff/tight		□ Stress
□ Traveling pain into arms/hands		□ Depression
		□ Memory loss
□ Pins/needles in arms/hands		
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_____

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_____

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Allergies _____

Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

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Pregnancies/Date of Delivery	Outcome (natural, C-section, complications, etc…)
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_____	_____
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_____

_____

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Work schedule: _____

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Preferred Name_____ Gender: Male / Female Height_____ Weight_____

Date of Birth_____/_____/_____ Age_____ Do you have Medicare? Yes / No

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City_____State_____Zip_____

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Primary reason: _____

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Chief Complaint: _____

_____

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□ Allergies	**Gastrointestinal**	**Neurologic**
□ Sinus Problems	□ Swallowing difficulties	□ Fainting
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_____	_____
_____	_____

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