



Dr./Mr./Mrs./Ms./Miss (circle one)

Marital status (circle one) M S W D

Sex  M  F

\_\_\_\_\_  
Last Name First Name MI Nick Name

\_\_\_\_\_  
Address City State Zip Code

Home phone# \_\_\_\_\_ Mobile Phone# \_\_\_\_\_

Email address \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone# \_\_\_\_\_

Person to contact in an emergency \_\_\_\_\_ Phone# \_\_\_\_\_

**Responsible Party**

Name of person responsible for payment of this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone# \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip Code

**Insurance Information**

If you have any insurance information please provide the staff with your insurance card and/or required forms.

**Primary Care Physician**

We would like to keep your doctor informed regarding your care. Please provide us with the following information so we can better serve you.

\_\_\_\_\_  
Doctor's Name Practice Name Phone #

\_\_\_\_\_  
Address City State Zip Code

**Symptoms**

1. Describe your area of greatest pain. \_\_\_\_\_

2. Please rate the level of this pain on the following scale: **0 is no pain, 10 is severe pain or the worst pain** you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.

**(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)**

3. When did this problem/pain start? \_\_\_\_\_  Gradual  Sudden  Progressive

4. What do you think caused this problem? \_\_\_\_\_

5. How often do you experience the pain?

- 1-2 hours per day
- Most of the day
- About half of the day
- The pain never goes away

6. How does the pain affect your daily activities?

- It does not affect my daily activities
- I have had to stop doing some of my daily activities
- I have had to change how I do things
- I am unable to perform daily activities

7. What **increases** your pain? \_\_\_\_\_

8. What **decreases** your pain? \_\_\_\_\_

9. Have you ever experienced this problem before?  Y  N When? \_\_\_\_\_

10. Have you been treated by another physician for this condition?  Y  N Who&When \_\_\_\_\_

11. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.

- a. \_\_\_\_\_ **0 1 2 3 4 5 6 7 8 9 10**
- b. \_\_\_\_\_ **0 1 2 3 4 5 6 7 8 9 10**
- c. \_\_\_\_\_ **0 1 2 3 4 5 6 7 8 9 10**
- d. \_\_\_\_\_ **0 1 2 3 4 5 6 7 8 9 10**

12. Have you ever been involved in an automobile accident? [ ] Y [ ] N      When? \_\_\_\_\_

Were you injured? [ ] Y [ ] N      Please explain \_\_\_\_\_

13. Have you ever been injured at work? [ ] Y [ ] N      When? \_\_\_\_\_

Please explain \_\_\_\_\_

14. List all medication you are currently taking (*prescribed and over the counter*) \_\_\_\_\_

\_\_\_\_\_

15. List all surgeries you have had (*with date*) \_\_\_\_\_

\_\_\_\_\_

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (*check all that apply*)

- |                               |   |                                     |                                |
|-------------------------------|---|-------------------------------------|--------------------------------|
| ___ heart attack              | ___ stroke                                | ___ arthritis                       | ___ gall bladder trouble       |
| ___ diabetes                  | ___ glaucoma                              | ___ fainting spells                 | ___ kidney stones              |
| ___ difficulty with urination | ___ bloody stools                         | ___ difficulty with bowel movements |                                |
| ___ prostate trouble          | ___ anemia                                | ___ cancer                          | ___ asthma                     |
| ___ AIDS                      | ___ ulcers                                | ___ diverticulosis                  | ___ menstrual cramping         |
| ___ dizziness                 | ___ loss of memory                        | ___ chest pain                      | ___ shortness of breath        |
| ___ constipation              | ___ diarrhea                              | ___ general fatigue                 | ___ sudden weight loss         |
| ___ nausea                    | ___ muscle cramping                       | ___ soreness in joints              | ___ loss of hearing            |
| ___ ears ringing              | ___ headache                              | ___ migraine                        | ___ epilepsy                   |
| ___ gout                      | ___ tuberculosis                          | ___ syphilis                        | ___ sprained ankle [ ] R [ ] L |
| ___ high blood pressure       | ___ neck pain or stiffness                | ___ numbness                        | ___ muscle weakness            |
| ___ knee/hip replacement      | ___ broken bones ( <i>specify</i> ) _____ |                                     |                                |

**General Activities** (*check all that apply*)

- |                         |                            |   |
|-------------------------|----------------------------|---|
| ___ sleep on waterbed   | ___ read in bed            | ___ fall asleep in recliner/on couch      |
| ___ sleep on stomach    | ___ needlepoint/knitting   | ___ use two or more pillows to sleep with |
| ___ sewing              | ___ lift weights/wt. mach. | ___ play video games ( _____ hrs per day) |
| ___ exercise _____ x/wk | ___ jog _____ x/wk         | ___ computer use ( _____ hrs per day)     |
| ___ swim                | ___ use health rider       | ___ watch television ( _____ hrs per day) |

**Nutrition:** \_\_\_ avg. servings of fruits and vegetables/day    \_\_\_ glasses of H2O/day    Do you take vitamins or minerals Y/N

**Habits:** Circle (H) Heavy, (M) Moderate, (L) Light, or (N) None: Alcohol: H/M/L/N    Coffee: H/M/L/N

Tobacco: H/M/L/N    Soda: H/M/L/N    Do you wear: Y/N heel/sole lifts    Y/N arch supports    Y/N Orthotics

**Family Health History:** Many health problems can be related to hereditary illnesses or spinal weakness; thus information about your family members will give us a better idea of your total health picture. Check all that apply.

- Father: \_\_\_ Heart Disease \_\_\_ Diabetes \_\_\_ Cancer (type \_\_\_\_\_) \_\_\_ Arthritis \_\_\_ Neck/Back Pain \_\_\_ Scoliosis Other \_\_\_\_\_
- Mother: \_\_\_ Heart Disease \_\_\_ Diabetes \_\_\_ Cancer (type \_\_\_\_\_) \_\_\_ Arthritis \_\_\_ Neck/Back Pain \_\_\_ Scoliosis Other \_\_\_\_\_
- Siblings: \_\_\_ Heart Disease \_\_\_ Diabetes \_\_\_ Cancer (type \_\_\_\_\_) \_\_\_ Arthritis \_\_\_ Neck/Back Pain \_\_\_ Scoliosis Other \_\_\_\_\_
- Spouse: \_\_\_ Heart Disease \_\_\_ Diabetes \_\_\_ Cancer (type \_\_\_\_\_) \_\_\_ Arthritis \_\_\_ Neck/Back Pain \_\_\_ Scoliosis Other \_\_\_\_\_
- Children: \_\_\_ Heart Disease \_\_\_ Diabetes \_\_\_ Cancer (type \_\_\_\_\_) \_\_\_ Arthritis \_\_\_ Neck/Back Pain \_\_\_ Scoliosis Other \_\_\_\_\_

**Authorization**

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

(signature of parent if the patient is a minor)