WELCOME TO OUR OFFICE

PATIENT:

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Date of Birth:___/___/___ Age: _____ SS#: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Email #: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

SPOUSE or GUARDIAN:

Last Name: _____ First Name: _____ Middle: _____

Employer Name: _____ Work Phone #: _____

Date of Birth:___/___/___ SS#: _____

EMERGENCY Name and address of nearest relative or friend **not living with you:**

Last Name: _____ First Name: _____ Middle: _____

Home Phone #: _____ Work Phone #: _____

Relation to Patient: _____

Primary Care Physician: _____

Phone #: _____

What is the main health problem you want to talk to the doctor about? _____

_____

How long have you had this condition? _____

What activities aggravate your condition? _____

Is this condition getting worse? ❑ Yes ❑ No ❑ Comes and goes ❑ Constant Number of episodes per day___ per week ___ per mo. ___

Condition interfering with your ❑ work ❑ sleep ❑ daily routine ❑ other _____

_____

Drugs you now take: ❑ Nerve pills ❑ Pain killers ❑ Muscle relaxers ❑ "Pep" pills ❑ Tranquilizers ❑ Birth control pills ❑ None ❑ Other

MEDICATION	DOSAGE	REASON	DOCTOR

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY:
Been knocked unconscious?	❑	❑	_____
Used a cane, crutch, or other support?	❑	❑	_____
Been treated for a spine or nerve disorder?	❑	❑	_____
Had any fractures or dislocations?	❑	❑	_____
Had any accidents or falls?	❑	❑	_____
Been hospitalized for other than surgery?	❑	❑	_____
Have you ever been in an auto accident?	❑	❑	_____

HEALTH REPORT

General
- ❑ Allergies _____
- ❑ Dizziness
- ❑ Headache
- ❑ Fainting
- ❑ Numbness
- ❑ Excessive weight loss
- ❑ Frequent loss of sleep

Muscle and Joint
- ❑ Arthritis
- ❑ Bursitis
- ❑ Swollen joints
- ❑ Poor posture
- ❑ Spinal curvature

Genito-Urinary
- ❑ Bed wetting
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Prostate trouble
- ❑ Kidney trouble

Gastro-intestinal
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Liver Trouble
- ❑ Gall bladder problems
- ❑ Vomiting of blood
- ❑ Poor appetite
- ❑ Nausea

Eyes, Ears, Nose, Throat
- ❑ Asthma
- ❑ Frequent Colds
- ❑ Deafness
- ❑ Earache
- ❑ Ear noises
- ❑ Eye pain
- ❑ Failing vision
- ❑ Frequent nosebleeds
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Hay fever

Cardio-vascular
- ❑ Stroke _____
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart rate
- ❑ Slow heart rate
- ❑ Swelling of ankles

Skin
- ❑ Bruise easily
- ❑ Itching
- ❑ Dryness

For Women Only
- ❑ Cramps or backache
- ❑ Excessive menstrual flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Painful menstruation

Are you pregnant? ❑ Yes ❑ No

Check the following conditions you have had:

- ❑ Alcoholism
- ❑ Arteriosclerosis
- ❑ Gout
- ❑ Rheumatic fever
- ❑ Cancer Type:_____
- ❑ Emphysema
- ❑ Heart disease
- ❑ Stroke
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Multiple sclerosis
- ❑ HIV/AIDS

HABITS:

Alcohol	❑ Heavy	❑ Moderate	❑ Light	❑ None
Caffeine	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

Do you wear? ❑ Custom orthotics ❑ Heel lifts ❑ Arch supports

Do you:

Now take vitamins or minerals? ❑ Yes ❑ No

Think you may need vitamins/minerals? ❑ Yes ❑ No

Have an allergy to drug or food? ❑ Yes ❑ No Type_____

Does any member of your family have: (please circle)

arthritis heart disease cancer diabetes epilepsy lung disease emotional problems intestinal disorders scoliosis spinal arthritis neck or back pains abnormal spinal development

other health problems? Yes / No Whom? Father Mother Sister Brother Aunt Uncle

I CERTIFY THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all services rendered. I agree that if my treatment here is suspended or terminated, fees become immediately due and payable. All X-rays are the property of this Chiropractic Center.

_____

SIGNATURE OF PATIENT OR GUARDIAN

FOR OFFICE USE ONLY, DO NOT WRITE IN THIS SPACE

PRIMARY COMPLAINT

Exact description of problem _____

_____

_____

Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness
Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to____ Severity 1 2 3 4 5 6 7 8 9 10
Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other
Better with: Exercise Rest Cold Heat Pain Pills Other _____
Related area of pain _____
Onset (how & when) _____ Date_____
Reoccurrence _____ Date_____ Same Better Worse than before
Related to fall or accident (describe) _____ Date_____
Did fall or accident occur at Home Work Other _____
Was Pt in Auto Accident _____ Date_____
Other circumstances assoc. with problem (complications) _____

_____

SECONDARY COMPLAINT

Exact description of problem _____

_____

_____

Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness
Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to____ Severity 1 2 3 4 5 6 7 8 9 10
Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other
Better with: Exercise Rest Cold Heat Pain Pills Other _____
Related area of pain _____
Onset (how & when) _____ Date_____
Reoccurrence _____ Date_____ Same Better Worse than before
Related to fall or accident (describe) _____ Date_____
Did fall or accident occur at Home Work Other _____
Was Pt in Auto Accident _____ Date_____
Other circumstances assoc. with problem (complications) _____

_____

THIRD COMPLAINT

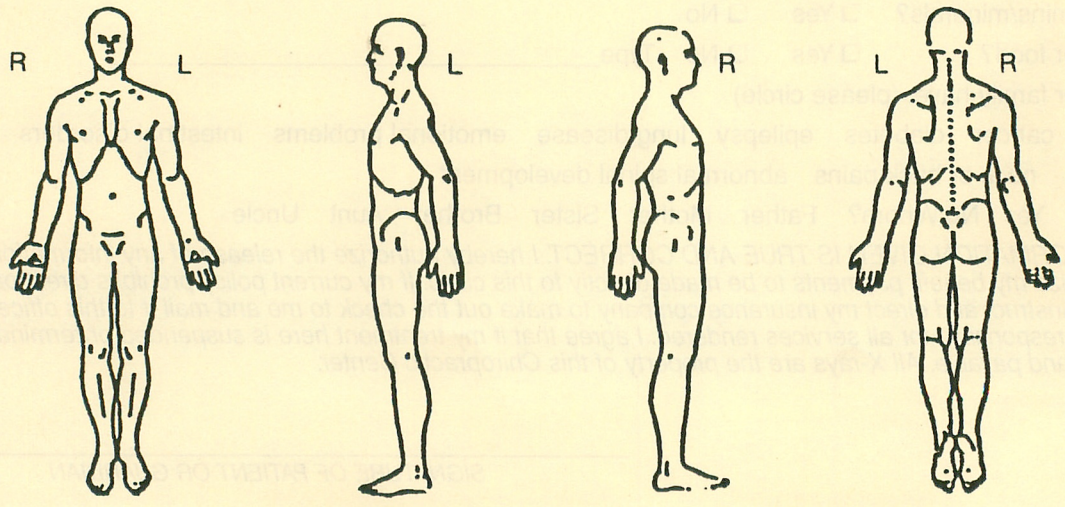
Exact description of problem _____

_____

_____

Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness
Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to____ Severity 1 2 3 4 5 6 7 8 9 10
Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other
Better with: Exercise Rest Cold Heat Pain Pills Other _____
Related area of pain _____
Onset (how & when) _____ Date_____
Reoccurrence _____ Date_____ Same Better Worse than before
Related to fall or accident (describe) _____ Date_____
Did fall or accident occur at Home Work Other _____
Was Pt in Auto Accident _____ Date_____
Other circumstances assoc. with problem (complications) _____

_____



Patient Denies Pregnancy

Signature:_____

Date:_____