

Welcome To Our Clinic

PATIENT INFORMATION

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Sex Male Female Birth date _____ Age _____
 Single Married Divorced Widowed
Social Security # _____ Spouses Name _____
Employer _____ Occupation _____
Whom may we thank for referring you? _____

CONTACT INFORMATION

Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Emergency Contact _____ Phone _____

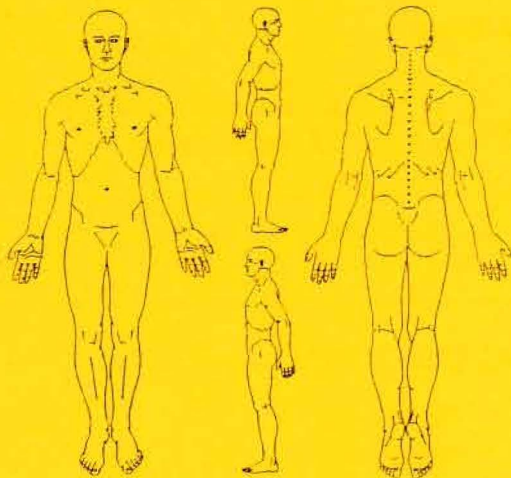
ACCIDENT INFORMATION

Are your complaints due to an accident? Yes No Date _____
Type of accident Auto Work Other _____
Attorney Name _____ Phone _____

PATIENT COMPLAINTS

Reason for visit _____
When did this occur? _____
How did this occur? _____
Is this getting? Worse Improving Staying the same
Type of pain: Sharp Aching/ dull Numbness/ tingling
 Shooting Constant Comes and goes
Severity of the pain: (no pain) 0...1...2...3...4...5...6...7...8...9...10 (most severe)
Limits my: Work Daily Activity Recreational Activity
 Sleep Sitting Standing Walking
 Bending Lying _____

Indicate where you have pain or other symptoms below:



For Dr. use only:

Onset _____
Pal/ prov _____

Quality _____
Radiating _____
Timing _____
Site _____

HEALTH HISTORY

What if any treatment have you received? _____

Have you ever seen a Doctor of Chiropractic before? Yes No

If yes, was it a positive experience? Yes No _____

Name of Family Physician or medical Doctor _____

Check yes or no to indicate if you have had any of the following:

AIDS/ HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mono	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple		Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding		Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyphoid	
Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated		Pollio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate		Vaginal	
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High		Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal	
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical		Kidney		Rheumatoid		Whooping	
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic		Migraine	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other: _____

Please list past Injuries/ Surgeries: _____ Date _____

Current Medications: _____ Allergies: _____ Vitamins/ Herbs/ Minerals: _____

LIFESTYLE / HABITS

Do you exercise : None Moderate Daily Heavy _____

Do you smoke? Yes No Packs per day _____

Alcoholic drinks per week _____ Glasses water per day _____ Carbonated drinks per day _____

My stress level is: low Moderate High Very High Astronomical

Where is the majority of your stress generated from? _____

Is There anything else that we should be aware of? _____

THANK YOU FOR COMPLETING THIS FORM