Patient Information

Name: _____
Address: _____
City _____ State _____ Zip Code _____
Phone #(____) ____-_____ Cell #(____) ____-_____
E-mail: _____
Age:____ DOB:__/__/__ Sex: Male ❑ Female ❑
Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑
Occupation: _____
Employer: _____
Work Phone # (____) ____-_____
Spouse's Name: _____
DOB: __/__/__
Cell #(____) ____-_____ Work #(____) ____-_____
Occupation: _____
Whom may we thank for referring you? Name / E-mail
_____

Emergency Contact Information

Name:_____ Relationship:_____
Home #(____) ____-_____Cell #(____) ____-_____

Patient Condition

Reason for visit: _____
When did your symptoms appear? _____
Is your condition getting worse? _____
Is this condition due to an accident? Yes ❑ No ❑
Type of accident: Auto ❑ Work ❑ Home ❑ Other _____❑
Date of accident: __/__/__
Rate your pain on a scale from 1 (least) to 10 (worst) ____
Type of pain: Dull ❑ Sharp ❑ Burning ❑ Throbbing ❑
Aching ❑ Shooting ❑ Numbness ❑ Tingling ❑
Cramping ❑ Stiffness ❑ Swelling ❑ Other _____ ❑
Is it consistent or does it come and go? _____
How often? Hourly ❑ Daily ❑ Weekly ❑ Monthly ❑
Does it interfere with Work ❑ Sleep ❑ Daily Routine ❑
Activities painful to perform: Sitting ❑ Standing ❑
Walking ❑ Bending ❑ Lying Down ❑ Other ❑
What treatment have you received for this condition?
None ❑ Medications ❑ Physical Therapy ❑ Surgery ❑
Chiropractic ❑ Other _____ ❑
Name and address of other doctors who have treated you:
_____
_____

Health History

Date of last:		Physical Exam	__/__/__
Spinal Exam	__/__/__	Spinal X-ray	__/__/__
Blood Test	__/__/__	Urine Test	__/__/__
MRI, CT scan	__/__/__	Bone scan	__/__/__
Are you pregnant?	_____	Due Date	__/__/__

Medications: _____
_____
_____
Allergies: _____
_____
_____

Vitamins / Herbs / Minerals: _____
_____
_____
_____
List and falls, surgeries, head injuries, broken bones, dislocations you have had with dates: (use back of sheet if needed) _____
_____
_____

Exercise

- ❑ None
- ❑ Light
- ❑ Moderate
- ❑ Heavy

Work Activity

- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

Habits

- ❑ Smoking ___ Packs/Day
- ❑ Alcohol ___ Drinks/Week
- ❑ Caffeinated Drinks ___ Cups/Day
- ❑ High Stress ❑ Reason

Check if you have or have ever had any of the following

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lumps
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disk
- ❑ Herpes
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Other _____
- ❑ Kidney disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors, Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

Please mark the Figure to show any area that has pain, tingling, or numbness.