Name
Address
City/Street
Date

Welcome to Our Office!

Patient Information

Home Phone #: _____

Cell Phone #: _____

Employer Name: _____

Occupation: _____

Employer Phone #: _____

Marital Status: Married Single Widowed Divorced
(Please Circle One)

Significant Other: _____

Phone #: _____

Social Security #: _____

Date of Birth: _____

Number of Children:_____

Emergency Contact: _____
(Not necessary if it is your significant other)

Relationship: _____
(Not necessary if it is your significant other)

Phone #: _____
(Not necessary if it is your significant other)

Primary Care Provider (PCP)

Name: _____

Phone #:_____

Why are you here today? Chief Complaint

_____

How were you referred? _____

Have you ever been to a chiropractor? Y / N

If yes, when was your last adjustment? _____

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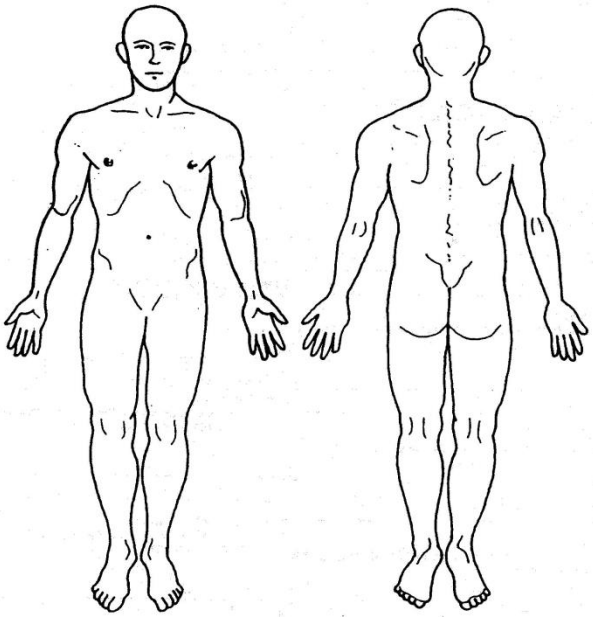
Condition Information

Mark the areas on your body where you feel your discomfort. Include all affected areas of radiation. If your discomfort radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as it travels. Use the appropriate symbol(s) listed below.

Ache > > > >	Numbness = = = =	Pins & Needles o o o o
Burning x x x x	Stabbing / / / /	Throbbing ~ ~ ~ ~



When did the condition begin? _____

Has it ever happened before? _____

Have you seen any other doctor for this condition? _____

If yes, when was your last treatment? _____

Is the condition:

___A Result of a Motor Vehicle Accident
MVA Claim Number: _____
___ A Result of a Worker's Compensation Injury
WC Claim Number: _____
___Other Injury
___No Injury

Quadruple Visual Analogue Scale

1. What is your pain RIGHT NOW?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Office Use Only: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

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Review of Systems

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Please fill out all sections, even if "None".

Constitutional:	☐ Chills	☐ Daytime Somnolence	☐ Fatigue	☐ Fever	☐ Night Sweats
☐ None	☐ Weight Gain	☐ Weight Loss			
Eyes/Vision:	☐ Blindness	☐ Blurred Vision	☐ Cataracts	☐ Change in Vision	☐ Double Vision
☐ None	☐ Eye Pain	☐ Field Cuts	☐ Glasses/Contacts	☐ Glaucoma	☐ Itching
☐ Photophobia	☐ Tearing				
ENT:	☐ Bleeding	☐ Dentures	☐ Difficulty Swallowing	☐ Discharge	☐ Dizziness
☐ None	☐ Ear Drainage	☐ Ear Pain	☐ Fainting	☐ Frequent Sore Throats	☐ Headaches
☐ Hearing Loss	☐ History of Head Injury	☐ Hoarseness	☐ Loss of Smell	☐ Nasal Congestion	☐ Nose Bleeds
☐ Post Nasal Drip (PND)	☐ Rhinorrhea (Runny Nose)	☐ Sinus Infections	☐ Snoring	☐ Tinnitus (Ringing in Ear)	☐ TMJ
Respiration:	☐ Asthma	☐ Cough	☐ Coughing up Blood	☐ Shortness of Breath (SOB)	☐ Sputum Production
☐ None	☐ Wheezing				
Cardio:	☐ Angina	☐ Chest Pain	☐ Claudication	☐ Heart Murmur	☐ Heart Problems
☐ None	☐ Orthopnea	☐ Palpitations	☐ PND	☐ SOB with Exertion	☐ Swelling of Legs
☐ Ulcers	☐ Varicose Veins				
Gastro:	☐ Abdominal Pain	☐ Belching	☐ Black Tarry Stools	☐ Constipation	☐ Diarrhea
☐ None	☐ Difficulty Swallowing	☐ Heartburn	☐ Hemorrhoids	☐ Indigestion	☐ Jaundice
☐ Nausea	☐ Rectal Bleeding	☐ Regurgitation	☐ Stool Caliber	☐ Stool Color	☐ Stool Consistency
☐ Vomiting	☐ Vomiting Blood				
Female:	☐ Breast Lumps/Pain	☐ Burning Urination	☐ Cramps	☐ Frequent Urination	☐ Irregular Menstruation
☐ None	☐ Urine Retention	☐ Vaginal Bleeding	☐ Vaginal Discharge		
Male:	☐ Burning Urination	☐ Erectile Dysfunction	☐ Frequent Urination	☐ Hesitancy/Dribbling	☐ Prostate
☐ None	☐ Urine Retention				
Endocrine:	☐ Cold Intolerance	☐ Diabetes	☐ Excessive Appetite	☐ Excessive Hunger	☐ Excessive Thirst
☐ None	☐ Frequent Urination	☐ Goiter	☐ Hair Loss	☐ Heat Intolerance	☐ Unusual Hair Growth
☐ Voice Changes					
Skin:	☐ Changes in Nail Texture	☐ Changes in Skin Color	☐ Hair Growth	☐ Hair Loss	☐ History of Skin Disorders
☐ None	☐ Hives	☐ Itching	☐ Paresthesias	☐ Pruritis	☐ Rash
☐ Skin Lesions/Ulcers	☐ Varicosities				
Nervous:	☐ Dizziness	☐ Facial Weakness	☐ Headache	☐ Limb Weakness	☐ Loss of Conciousness
☐ None	☐ Loss of Memory	☐ Numbness	☐ Seizures	☐ Sleep Disturbance	☐ Slurred Speech
☐ Stress	☐ Strokes	☐ Tremor	☐ Unsteadiness of Gait		
Psychological:	☐ Anhedonia	☐ Anxiety	☐ Appetite	☐ Behavioral Change	☐ Bipolar
☐ None	☐ Confusion	☐ Depression	☐ Insomnia	☐ Memory Loss	☐ Mood Change
Allergy:	☐ Anaphalaxis	☐ Food Intolerance	☐ Itiching	☐ Nasal Congestion	☐ Sneezing
☐ None					
Hematology:	☐ Anemia	☐ Bleeding	☐ Blood Clotting	☐ Blood Transfusions	☐ Bruising
☐ None	☐ Fatigue	☐ Lymph Node Swelling			

Past Health History

Please fill out the information below carefully as these problems could affect your overall course of treatment.

Childhood Illnesses:	☐ ADD	☐ Allergies/Hayfever	☐ Asthma	☐ Atopic Dermatitis	☐ Cerebral Palsy
☐ None	☐ Depression	☐ Diabetes	☐ Fetal Drug Exposure	☐ Food Allergies	☐ Headaches

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☐ Measles	☐ Mumps	☐ Rash	☐ Seizure Disorder	☐ Sickle Cell Anemia	☐ Unusual Childhood Illness

Adult Illnesses:	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Cancer	☐ Chicken Pox
☐ None	☐ CVA (Stroke)	☐ Depression	☐ Diabetes (Insulin Dep)	☐ Diabetes (NIDDM)	☐ Eye Problems
☐ Hepatitis	☐ Hypertension	☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease	☐ Seizures
☐ Similar Symptoms	☐ STD's	☐ Suicide Attempts	☐ Thyroid Problem		

Surgeries:	☐ Angioplasty	☐ Appendectomy	☐ Caesarean Section	☐ Cardiac Catheterization	☐ Carpal Tunnel Release
☐ None	☐ Cosmetic	☐ D&C	☐ Hemorrhoidectomy	☐ Hernia Repair	☐ Hysterctomy
☐ Joint Replacement	☐ Laminectomy	☐ Mastectomy	☐ Pacemaker Insertion	☐ Spinal Fusion	☐ Gallbladder

☐ Other(s): _____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or present? Yes No (Please Circle One)

If yes, please explain: _____

Are there any other conditions we should know about, even if unrelated? _____

Have you had any previous: X-ray MRI CT (please circle) Other _____

Have you had previous Chiropractic care before? Yes No (Please Circle One)

If yes, when was your last treatment? _____

Has anyone else in your family experienced this condition? Yes No (Please Circle One)

WOMEN ONLY:

Are you pregnant or is there any possibility that you may be pregnant?

Yes No Uncertain N/A (Please Circle One)

Social History

Alcohol:	☐ None	☐ Beer	☐ Liquor	☐ Social Consumption
Diet:	☐ High Fat Diet	☐ High Fiber	☐ High Protein	☐ High Salt Intake
	☐ Low Calorie Intake	☐ Low Carbohydrate	☐ Low Fiber	☐ Low Salt

Education: ☐ Level or Degree Attained: _____

Substance: ☐ Denies Any ☐ Denies IV Drugs Not Used Since: _____

Tobacco: Type(s): _____