

Patient Data

Date: _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss (check one)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Date of Birth: ____/____/____ **Sex:** ☐ Male ☐ Female **Email:** _____

Social Security Number: _____ - _____ - _____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐ Yes ☐ No

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Employer Data

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____ - _____

Is it okay to call you at work?

☐ Yes ☐ No

How did you hear about our clinic? Or who referred you?

<input type="checkbox"/> Family member	<input type="checkbox"/> Attorney	<input type="checkbox"/> Internet web site	<input type="checkbox"/> Health class
<input type="checkbox"/> Friend	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Billboard	<input type="checkbox"/> Brochure
<input type="checkbox"/> Physician	<input type="checkbox"/> Newspaper ad	<input type="checkbox"/> TV Commercial	<input type="checkbox"/> Direct mail ad
<input type="checkbox"/> Employer	<input type="checkbox"/> Sign on building	<input type="checkbox"/> Radio	<input type="checkbox"/> Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Medical Conditions:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Psychiatric Illness	<input type="checkbox"/> Skin Disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		

Surgeries:

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cardiovascular procedure	<input type="checkbox"/> Cervical disc procedure	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Laminectomies	<input type="checkbox"/> Radical prostatectomy	<input type="checkbox"/> Transurethral prostate surgery
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		

Allergies:

<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish and Shellfish	<input type="checkbox"/> Milk or Lactose	<input type="checkbox"/> Peanut
<input type="checkbox"/> Soy	<input type="checkbox"/> Sulfites	<input type="checkbox"/> Wheat/Gluten	<input type="checkbox"/> Other _____

Social History:

<input type="checkbox"/> Caffeine used occasionally	<input type="checkbox"/> Caffeine used often	<input type="checkbox"/> Chew tobacco occasionally	<input type="checkbox"/> Chew tobacco often
<input type="checkbox"/> Drink alcohol occasionally	<input type="checkbox"/> Drink alcohol often	<input type="checkbox"/> Exercise not at all	<input type="checkbox"/> Exercise occasionally
<input type="checkbox"/> Exercise often	<input type="checkbox"/> Experience stress occasionally	<input type="checkbox"/> Experience stress often	<input type="checkbox"/> Smoke 1 pack or less per day
<input type="checkbox"/> Smoke more than 1 pack a day	<input type="checkbox"/> Wear seat belts always	<input type="checkbox"/> Wear seat belts never	<input type="checkbox"/> Wear seatbelts usually

Family History:

<input type="checkbox"/> Arthritis (parent)	<input type="checkbox"/> Arthritis (sibling)	<input type="checkbox"/> Cancer (parent)	<input type="checkbox"/> Cancer (sibling)
<input type="checkbox"/> Cholesterol (parent)	<input type="checkbox"/> Cholesterol (sibling)	<input type="checkbox"/> Diabetes (parent)	<input type="checkbox"/> Diabetes (sibling)
<input type="checkbox"/> Heart problems (parent)	<input type="checkbox"/> Heart problems (sibling)	<input type="checkbox"/> High blood pressure (parent)	<input type="checkbox"/> High blood pressure (sibling)
<input type="checkbox"/> Psychiatric (parent)	<input type="checkbox"/> Psychiatric (sibling)	<input type="checkbox"/> Stroke (parent)	<input type="checkbox"/> Stroke (sibling)
<input type="checkbox"/> Thyroid (parent)	<input type="checkbox"/> Thyroid (sibling)	<input type="checkbox"/> Other _____	

Substance Use:

<input type="checkbox"/> Alcohol (past)	<input type="checkbox"/> Alcohol (present)	<input type="checkbox"/> Amphetamines (past)	<input type="checkbox"/> Amphetamines (present)
<input type="checkbox"/> Barbiturates (past)	<input type="checkbox"/> Barbiturates (present)	<input type="checkbox"/> Cocaine (past)	<input type="checkbox"/> Cocaine (present)
<input type="checkbox"/> Crystal Meth (past)	<input type="checkbox"/> Crystal Meth (present)	<input type="checkbox"/> Heroin (past)	<input type="checkbox"/> Heroin (Present)
<input type="checkbox"/> Marijuana (past)	<input type="checkbox"/> Marijuana (present)	<input type="checkbox"/> Other _____	

Male Children:

<input type="checkbox"/> Under 6 years	<input type="checkbox"/> Under 10 years	<input type="checkbox"/> Under 19 years
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Female Children:

<input type="checkbox"/> Under 6 years	<input type="checkbox"/> Under 10 years	<input type="checkbox"/> Under 19 years
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Occupational Activities:

<input type="checkbox"/> Administration	<input type="checkbox"/> Business owner	<input type="checkbox"/> Clerical/secretarial	<input type="checkbox"/> Computer user
<input type="checkbox"/> Construction	<input type="checkbox"/> Daycare/childcare	<input type="checkbox"/> Executive/legal	<input type="checkbox"/> Food service industry
<input type="checkbox"/> Health care	<input type="checkbox"/> Heavy equipment operator	<input type="checkbox"/> Heavy manual labor	<input type="checkbox"/> Home services
<input type="checkbox"/> Household	<input type="checkbox"/> Light manual labor	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Medium manual labor
<input type="checkbox"/> Household	<input type="checkbox"/> Light manual labor	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Medium manual labor

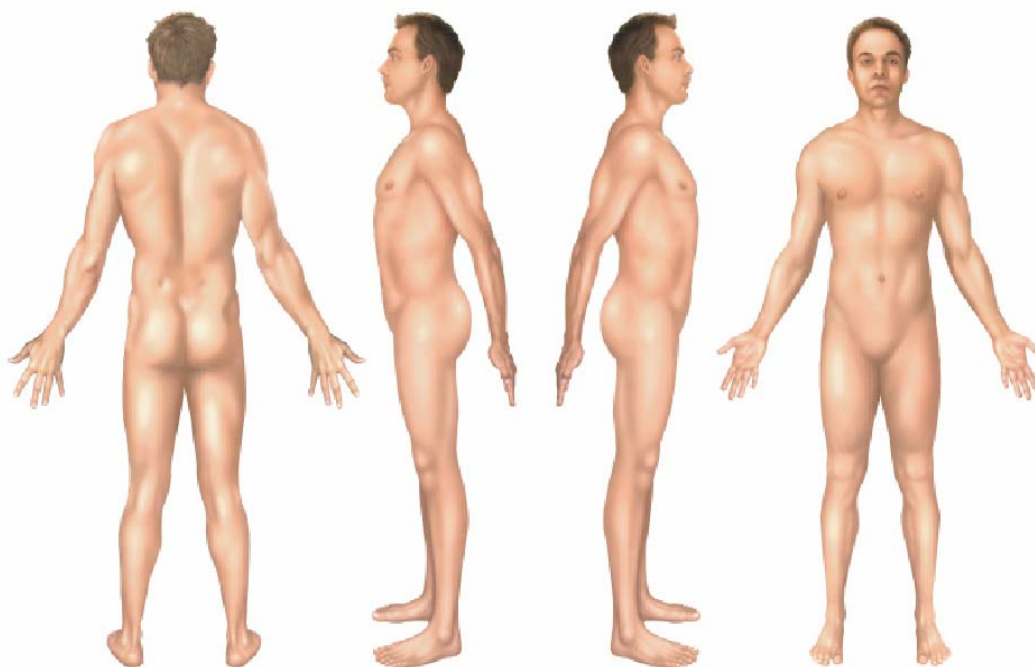
- | | | | |
|---------------------------------------|--------------------------------------|---|----------------------------------|
| <input type="checkbox"/> Military | <input type="checkbox"/> Police/fire | <input type="checkbox"/> Professional Service | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> Truck driver | <input type="checkbox"/> Other _____ | | |

Recreational Activities:

- | | | | |
|--------------------------------------|---|--|-----------------------------------|
| <input type="checkbox"/> Backpacking | <input type="checkbox"/> Biking | <input type="checkbox"/> Boating | <input type="checkbox"/> Football |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Racket ball | <input type="checkbox"/> Rock climbing | <input type="checkbox"/> Running |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Weight lifting | Other _____ | |

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

What describes the nature of your symptoms?

- | | | | |
|----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull ache | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | |

How are your symptoms changing?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Getting better | <input type="checkbox"/> Not changing | <input type="checkbox"/> Getting worse |
|---|---------------------------------------|--|

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- | | | | |
|---------------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
|---------------------------------|----------------------------|----------------------------|----------------------------|

- | | | | |
|----------------------------|----------------------------|--|----------------------------|
| <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 |
| <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 Unbearable | |

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- | | | | |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Extremely | | | |

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> All of the time | <input type="checkbox"/> Most of the time | <input type="checkbox"/> Some of the time | <input type="checkbox"/> A little of the time |
| <input type="checkbox"/> None of the time | | | |

In general, would you say your overall health right now is....

- | | | | |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Very good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Poor | | | |

Who have you seen for your symptoms:

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> No one | <input type="checkbox"/> Other Chiropractor | <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Other _____ | | | |

What treatment did you receive for your symptoms?

- | | | | |
|--------------------------------------|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Adjustments | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Other _____ | | | |

When did you receive this treatment?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> In the last month | <input type="checkbox"/> 2 – 3 months ago | <input type="checkbox"/> 3 – 6 months ago | <input type="checkbox"/> 6 months to 1 year ago |
| <input type="checkbox"/> 1 – 2 years ago | <input type="checkbox"/> 2 – 5 years ago | <input type="checkbox"/> 5 – 10 years ago | |

What tests have you had for your symptoms?

- | | | | |
|---------------------------------|------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> MRI | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Other |
|---------------------------------|------------------------------|----------------------------------|--------------------------------|

When were these tests done?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> In the last month | <input type="checkbox"/> 2 – 3 months ago | <input type="checkbox"/> 3 – 6 months ago | <input type="checkbox"/> 6 months to 1 year ago |
| <input type="checkbox"/> 1 - 2 years ago | <input type="checkbox"/> 2 – 5 years ago | <input type="checkbox"/> 5 – 10 years ago | |

Have you had similar symptoms in the past?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> This Office | <input type="checkbox"/> Other Chiropractor | <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Other _____ | | | |

What is your occupation?

- | | | | |
|---|---|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Professional/Executive | <input type="checkbox"/> White Collar/Secretarial | <input type="checkbox"/> Tradesperson | <input type="checkbox"/> Laborer |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Full-time Student | <input type="checkbox"/> Retired | <input type="checkbox"/> Other |

If you are not retired, a homemaker or a student, what is your work status?

- | | | | |
|------------------------------------|--------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Full-time | <input type="checkbox"/> Part-time | <input type="checkbox"/> Self-employed | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Off work | <input type="checkbox"/> Other _____ | | |

Thank you. Please return to the front desk.

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

No

Present

Past

No

Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary:

No

Present

Past

No

Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic:

No

Present

Past

No

Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic:

No

Present

Past

No

Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory:

No

Present

Past

No

Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat:

No

Present

Past

No

Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes:

No

Present

Past

No

Glaucoma			
Double Vision			
Blurred Vision			

Integumentary:

No

Present

Past

No

Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric:

No

Present

Past

No

Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional:

No

Present

Past

No

Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic:

No

Present

Past

No

Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal:

No

Present

Past

No

Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal:

No

Present

Past

No

Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine:

No

Present

Past

No

Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			