

Demographic Information

* Denotes required information

Patient Name

Title: _____
Nick Name: _____
*First Name: _____
Middle Name: _____
*Last Name: _____
Suffix: _____

Address

Address 1: _____
Address 2: _____
City: _____
State: _____
*Zip: _____

Contact Information

Primary phone: _____
Secondary phone: _____
Mobile phone: _____
Work email: _____
Home email: _____
Best Contact Method: _____

Personal Information

*Date of Birth: _____
Social Security Number: _____
*Gender: _____
Marital Status Single Married Other
Employment Status: Employed FT Student PT Student Retired Other Self Employed
Race: White Black/African American Hispanic American Indian/Alaska Native
 Asian Indian Chinese Filipino Japanese Korean Vietnamese
 Native Hawaiian/Pacific Islander Guamanian or Chamorro Samoan Other
Multi-Racial: Yes No
Ethnicity: Hispanic or Latino Non-Hispanic or Latino
Preferred language: _____

Verification Question: In what city were you born? What is the name of your favorite pet?
 What high school did you attend? What street did you grow up on?
 What is your favorite color? What was the make of your first car?
 What is your favorite movie? When is your anniversary?

Verification Answer: _____

Name of primary care physician: _____

Have you ever consulted a chiropractor before? Yes No

If so, who: _____
Last visit: _____
Referred by: _____

Employment Information

* Denotes required information

*Occupation: _____

Employer Name: _____

Employer Address: _____

Employer City: _____

Employer State: _____

Employer Zip: _____

Work Phone: _____

May we call your cell phone at work: Yes No

May we call your work phone: Yes No

Other Health Care Providers

* Denotes required information

*Provider Name: _____

Provider Type: _____

Provider City: _____

Provider State: _____

Provider Phone: _____

*I have seen this provider for my primary problems: Yes No

*Provider Name: _____

Provider Type: _____

Provider City: _____

Provider State: _____

Provider Phone: _____

*I have seen this provider for my primary problems: Yes No

*Provider Name: _____

Provider Type: _____

Provider City: _____

Provider State: _____

Provider Phone: _____

*I have seen this provider for my primary problems: Yes No

Problem Areas

* Denotes required information

*Describe your problem: _____

*On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

*How did your problem begin: _____

*Onset date of problem: _____

How often do you experience symptoms: _____

What is the nature of your symptoms: Dull Sharp Throbbing Burning Deep
 Aching Tingling Stabbing Cramping
 Numbness Radiating

Does it affect other areas of your body: Yes No

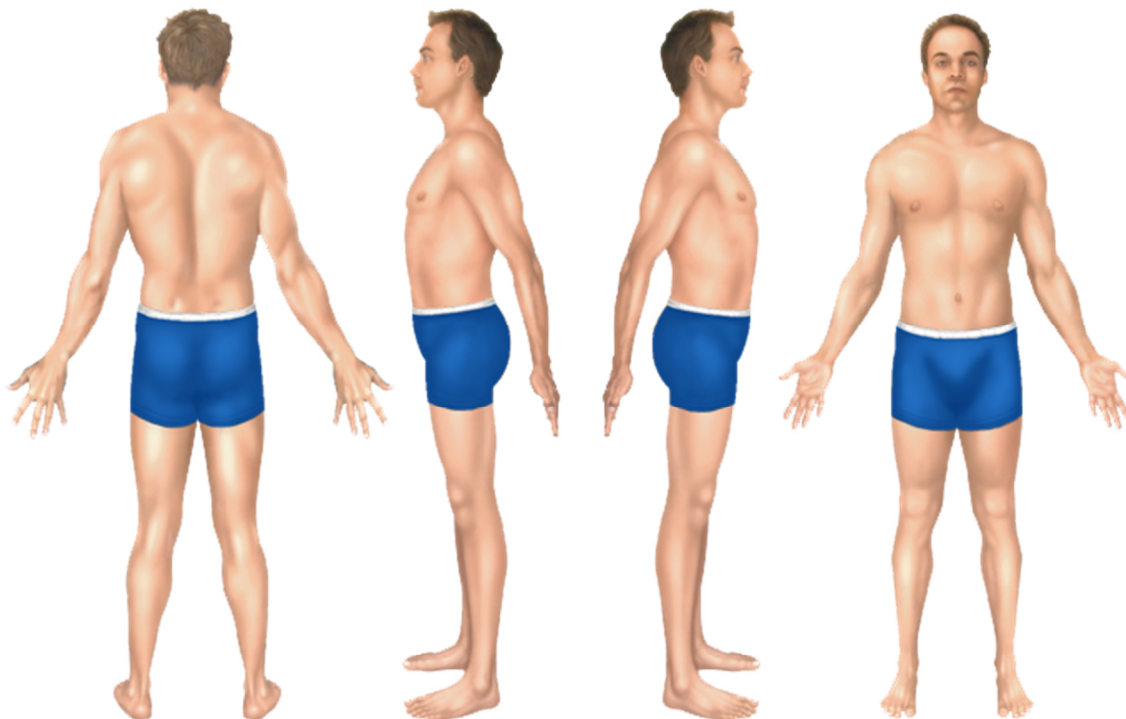
To what areas does the pain radiate, shoot or travel: _____

What makes it better or worse? (Times of day, movements, activities): _____

What have you done to relieve the symptoms: Prescription Medication Over the counter drugs
 Homeopathic remedies Physical Therapy
 Surgery Acupuncture Chiropractic
 Massage Ice Heat Other

*What should we know about your current condition: _____

Location of symptoms



Medications

* Denotes required information

*Name: _____

Dosage: _____

*Start Date: _____

*Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

*Name: _____

Dosage: _____

*Start Date: _____

*Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

*Name: _____

Dosage: _____

*Start Date: _____

*Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

Nutritional Supplements

* Denotes required information

*Name: _____

*Start Date: _____

Manufacturer: _____

Quantity: _____

Frequency: _____

Taken with water: Yes No

Reason for taking: _____

Comments: _____

*Name: _____

*Start Date: _____

Manufacturer: _____

Quantity: _____

Frequency: _____

Taken with water: Yes No

Reason for taking: _____

Comments: _____

Allergies

* Denotes required information

*Name: _____
Medication related: Yes No
Symptom: _____
*Start Date: _____
Comments: _____

*Name: _____
Medication related: Yes No
Symptom: _____
*Start Date: _____
Comments: _____

Personal Medical History

Illnesses

Illness: _____
Start date: _____
End date: _____

Illness: _____
Start date: _____
End date: _____

Surgeries

Surgery: _____
Date: _____

Surgery: _____
Date: _____

Hospitalizations

Reason: _____
Date: _____
Duration: _____

Reason: _____
Date: _____
Duration: _____

Injuries

Injury: _____
Date: _____

Injury: _____
Date: _____

Family Medical History

Illnesses

Illness: _____
Relation: _____
Age of onset: _____

Illness: _____
Relation: _____
Age of onset: _____

Illness: _____
Relation: _____
Age of onset: _____

Illness: _____
Relation: _____
Age of onset: _____

Review of Body Systems

Musculoskeletal	<input type="checkbox"/> No issues		
Osteoporosis:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Arthritis:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Scoliosis:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Neck Pain:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Back Problems:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Hip Disorders:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Knee injuries:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Foot/ankle pain:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Shoulder Problem:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Elbow/Wrist Pain:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
TMJ Issues:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Poor Posture:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Neurological	<input type="checkbox"/> No issues		
Anxiety:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Depression:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Headaches:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Dizziness:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Pins & needles:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Numbness:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> No issues		
High Blood Pressure:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Low Blood Pressure:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
High cholesterol:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Poor circulation:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Angina:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Excessive bruising:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Respiratory	<input type="checkbox"/> No issues		
Asthma:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Apnea:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Emphysema:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Hay fever:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Shortness of breath:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Pneumonia:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Digestive	<input type="checkbox"/> No issues		
Anorexia/bulimia:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Ulcer:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Food sensitivities:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Heartburn:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Constipation:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Diarrhea:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Sensory	<input type="checkbox"/> No issues		
Blurred vision:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	ringing in ears:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Hearing loss:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Chronic ear infection:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Loss of smell:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Loss of taste:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Integumentary	<input type="checkbox"/> No issues		
Skin cancer:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Psoriasis:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Eczema:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Acne:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Hair loss:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Rash:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Endocrine	<input type="checkbox"/> No issues		
Thyroid issues:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Immune disorders:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Hypoglycemia:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Frequent infection:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Swollen glands:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Low energy:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Genitourinary	<input type="checkbox"/> No issues		
Kidney stones:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Infertility:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Bedwetting:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Prostate issues:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Erectile dysfunction:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	PMS symptoms:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Constitutional	<input type="checkbox"/> No issues		
Fainting:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Low libido:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Poor appetite:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Fatigue:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No
Sudden weight gain/loss:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No	Weakness:	<input type="checkbox"/> Have <input type="checkbox"/> Had <input type="checkbox"/> No

Smoking History

* Denotes required information

*Do you currently smoke: Yes No

Years smoked: _____

Packs a day: _____

Interest in quitting on a scale of 0-10: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

How long since you stopped: _____

Social History

* Denotes required information

Consumption

How much alcohol do you drink daily: _____

How many cups of coffee do you drink daily: _____

How much soda pop do you drink daily: _____

How much water do you drink daily: _____

How much do you depend on pain relievers: _____

Do you use recreational drugs: Yes No

Stress Information

*How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

*How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

What are the major stressors in your life: _____

Sleeping Information

How many hours do you sleep per night: _____

What is your preferred sleeping position: _____

What type of mattress & pillow do you have: _____

How old are your mattress & pillow: _____

Healthy Eating & Exercise Information

How much regular exercise do you perform: _____

*Rate your healthy eating habits: Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy

Typical eating habits: Skip Breakfast 2 meals per day 3 meals per day

Snacking between meals

What would be the most significant thing that would improve your health:

What additional health goals do you have:

Daily Activities

* Denotes required information

Rate the difficulty of the following daily activities on a scale of 0-10 (0 being easiest, 10 most difficult):

<u>Activity</u>	<u>*Current Difficulty</u>										<u>*Prior Difficulty</u>											
Bending:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Carrying:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Driving:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Housework:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Lying:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Opening jars:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Personal care:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Picking up objects:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Pulling:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Pushing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Reaching:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Reaching behind:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Reading:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Recreation:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Running:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Shopping:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Sit to stand:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Sitting:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Sleeping:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Standing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Throwing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Walking:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Writing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

Comments: _____

Acknowledgements

- Chiropractic care:** I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
- Privacy Verification:** I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
- Permission to contact:** I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
- Payment Verification:** I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
- X-ray Verification:** I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks.
(females only)
- Date of last menstrual period:
- General Verification:** To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____ Date: _____