

1 PATIENT INFORMATION

Name: _____
(First) (Initial) (Last) (Name called by)

Address: _____

Birthdate: _____ Age: ____ Male Female

Social Security # _____/_____/_____

Occupation: _____

Employer: _____

Parents Name(if a minor): _____

Single Married Divorced Widowed Separated

Spouse's Name: _____

of Children: __ Name(s) _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance company _____

Insurance ID number _____

Group / Claim number _____

Is patient covered by additional insurance? Yes No

Insurance company _____

Subscriber # and name _____

Birthdate _____ Group # _____

Please present insurance card(s) so we can put a copy in your file.

3 ACCIDENT INFORMATION

Is your condition due to an accident? No Yes Date: _____

Type of accident? Automobile Work Home Other

To whom have you reported the accident?

Insurance Worker's Comp Employer Other _____

Attorney Name (If applicable) _____

4 CONTACT INFORMATION

Home phone _____

Cell phone _____

Work Phone _____ Ext _____

Email _____

Best way to reach you Home Cell Work Email

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell _____

5 PATIENT CONDITION

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes No

Is this problem: constant comes and goes

How does it Feel? Burning Sharp Shooting Dull Aching Stiff
 Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:
 (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/movements that are painful to perform:
 Sitting Standing Walking Bending Lying down Driving Reading Getting Up

Please mark where it hurts

The image shows four line drawings of a human figure from the front, back, left side, and right side. Above the drawings is the text 'Please mark where it hurts'. The drawings are intended for the patient to mark specific areas of their body where they experience pain.

6

HEALTH HISTORY

What other treatments have you had for this condition?

- Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery

Name of other doctors who have treated you for this condition

Describe the other doctor's treatment for your condition

Previous Chiropractic care? No Yes Date Local Out of state

Date of Last: Physical Exam Spinal x-ray MRI Spinal Exam Dental x-ray CT- Scan

List any Medications you are taking

Vitamins / Herbs / Minerals

Females: Are you Pregnant Yes No Beginning of last menstrual cycle

Check any of the following conditions you have had:

- AIDS/HIV Allergies Anxiety/Depression Arm/shoulder pain Arthritis Asthma Bladder problems Cancer Chronic fatigue Deafness Diabetes Digestion problems Earache Ear ringing Epilepsy Headaches Headaches - Migraine Heart Disease Hemorrhoids Herniated disk High blood pressure Insomnia Irregular cycle Kidney problems Leg pain Low back pain Neck pain Osteoporosis Poor circulation Prostate problems Rheumatoid Arthritis Sciatica Shingles Sinus infection Stroke Thyroid problems TMJ Venereal disease Vertigo/Dizziness

STRESSORS

- Smoking Alcohol Coffee/ Caffeine Drinks High Stress Level Packs/Day Drinks/Week Cups/Day Reason

EXERCISE

- None Moderate Daily Heavy

Table with 3 columns: Have you had any, Description, Date. Rows include Automobile accidents, Surgeries, Broken bones, Falls/Head injuries.