SONORAN CHIROPRACTIC

Patient Information:

First Name: _____ MI: ____ Last Name: _____

Date Of Birth: _____ /_____/_____ Preferred Name: _____

Address: _____ City/State/Zip: _____

Phone Number: (_____) _____-_____ Work Number: (_____) _____-_____

Email Address: _____

Gender: _____ Social Security Number: _____-_____-_____

Marital Status (please circle one): M S W D Spouse Name: _____

Employer: _____ Title: _____

Referred by: _____

Primary Care Physician: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Phone Number: (_____) _____-_____ Work Number: (_____) _____-_____

Complaint:

Reason(s) for visit:_____

Is this condition due to an accident? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Home ☐ Other Date: _____

How did your problem arise? _____

When did your symptoms appear? _____ Is it constant or does it come and go? _____

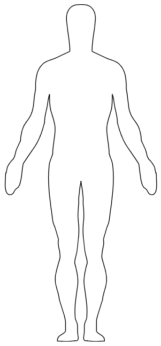
How often do you have this problem? _____ How long does the pain last? _____

Does the pain radiate? ☐ Yes ☐ No If yes, Explain: _____

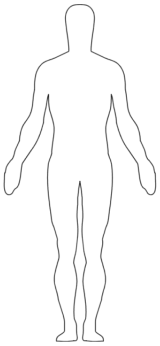
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ None

Activities that are difficult/painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Mark an "X" on the picture where you continue to have pain, numbness or tingling.



Front



Back

Circle your pain on the below scale of 0 to 10:

(at rest) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

(with activity) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

What time of day is your current pain/problem worse?

☐Morning ☐ Late in the day ☐ Middle of night ☐ As day progresses ☐ N/A

Patient initial:_____

My current pain/problem seems to be: ☐ Getting better ☐ Staying the same ☐ Getting worse ☐ N/A
My current pain/problem can be described as (check all that apply):
☐ Electric ☐ Sharp ☐ Stabbing ☐ Knife-like ☐ Piercing ☐ Shooting ☐ Achy ☐ Griping ☐ Heavy ☐ Cramp-like ☐ Burning ☐ Deep ☐ Superficial ☐ Stiffness (AM or PM or Both) ☐ Spasm ☐ Tearing ☐ N/A
What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None

Health History:

Are you allergic to any of the following? ☐Bee Stings ☐Peanuts/nuts ☐Dairy ☐Eggs ☐Wheat ☐ Shellfish ☐ Mold ☐Latex ☐Pollen ☐Medications ☐Other: _____
Current Medications and supplements: Please list current medications with frequency and dosages, if known.
If you currently take NO medications check here ☐

	Medication/Supplements	Frequency	Dosage	Start Date
1				
2				
3				
4				
5				

Do you wear any of the following? ☐ Heel Lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics ☐ Other_____
For how long? _____ Are they prescribed by a doctor? ☐ Yes ☐ No
Have you seen a chiropractor in the past? ☐ Yes ☐ No Date of last visit: _____/_____/_____

Date of last:	X-Ray	
	CT Scan	
	MRI	
	Bone Density	

Check if you have the following:

☐Abdominal Pain	☐Dizziness/Confusion	☐Prior Surgery/replacements
☐Autoimmune Condition	☐Fused joints/rods/screws	☐Osteopenia/Osteoporosis
☐Blood Transfusion	☐Headaches	☐Scoliosis
☐Cancer/Tumors	☐High Blood Pressure	☐Seizures
☐Diabetes	☐Pacemaker	☐Stroke

If yes, please explain:_____
_____
Are you pregnant? ☐No ☐Yes, How long? _____

Body Stressors:

Do your daily activities require you to lift heavy objects? ☐ Yes ☐ No If yes, Explain: _____
Do your daily activities require you to stand or sit for long periods at a time? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, How often? What type? _____
Do you drink Caffeine? ☐ Yes ☐ No If yes, How much?_____
Overall, how do you rate your diet? ☺ 10 9 8 7 6 5 4 3 2 1 ☹

_____ _____
Patient or Legal Guardian Signature Date

Patient initial:_____