Date: ___________________

Patient Information:

Name: ____

Address: ____

City: ____ State: _________________ Zip: ________________________

Cell Phone: _________-__________-_____________ Home/Other Phone: __________-__________-_____________

Email Address: __________________________________ Occupation: _______________________________________

Date of Birth: ________________________________ Gender: Male - Female

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Other

Whom may we thank for referring you to our office? ____

Insurance:

Name of Insurance Company: ____

Member ID#: ____

Relationship to Insured: □ Self □ Spouse □ Dependent □ Other

Insured's Name:___________________________________ Insured's Date of Birth:________________________________

HEALTH HISTORY

List any **Allergies**:

☐ Medications: ____ ☐ Other: ____

List any **Surgeries**:

☐ Neck Surgery ☐ Spinal Surgery ☐ Hip ☐ Hip Replacement ☐ Knee ☐ Knee Replacement ☐ Shoulder

☐ Wrist/Hand ☐ Foot/Ankle ☐ Other: ____

List **Past Medical History** conditions:

☐ Arthritis ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition ☐ Hearing Problems

☐ Heart Disease ☐ Multiple Sclerosis ☐ Parkinson's ☐ Polio ☐ Spinal Cord Injury ☐ Stroke

Do you have a pacemaker? ☐ Yes ☐ No Other metal implant? ____

List of **Medications** you are taking:

____ Reason for taking____

____ Reason for taking____

____ Reason for taking____

____ Reason for taking____

____ Reason for taking____

Family History:

Mother: ☐ Arthritis ☐ Back Pain ☐ Cancer, site: __________ ☐ Heart Disease ☐ Stroke

Father: ☐ Arthritis ☐ Back Pain ☐ Cancer, site: __________ ☐ Heart Disease ☐ Stroke

List any **Auto or Other Accidents:**

Describe: ____

Social History:

Do you smoke? ☐ Current smoker ☐ Former smoker ☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No How many per day? __________ Week? __________ Month? __________

Do you exercise? ☐ No ☐Yes (what forms and how often): ____

Have you had any X-rays, MRI or scans related to your visit today? ☐ Yes ☐ No

If yes, what did you have done and where? ____

Patient reported: Height __________ft. __________in Weight __________lbs.

Review of Systems: (Check all that apply)

General
- ☐ Fever
- ☐ Weight change
- ☐ Weakness
- ☐ Fatigue
- ☐ Cancer

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath on exertion
- ☐ Heart palpitations
- ☐ Pain in legs when walking
- ☐ Leg swelling
- ☐ Rest pain in legs
- ☐ Skin color changes
- ☐ Irregular heart rhythm

Neurological
- ☐ Numbness/tingling
- ☐ Seizures
- ☐ Dizziness
- ☐ Speech changes
- ☐ Leg/arm weakness
- ☐ Tremors
- ☐ Sensory change

Eyes
- ☐ Blindness
- ☐ Blurred vision
- ☐ Double vision

Respiratory
- ☐ Apnea
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Blood in sputum

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Heme/Lymphatic
- ☐ Swollen nodes
- ☐ Abnormal bleeding/bruising

ENT
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Sinus pain

Gastrointestinal
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Diarrhea
- ☐ Blood in stool

Skin
- ☐ Itching
- ☐ Rash
- ☐ Skin lesion

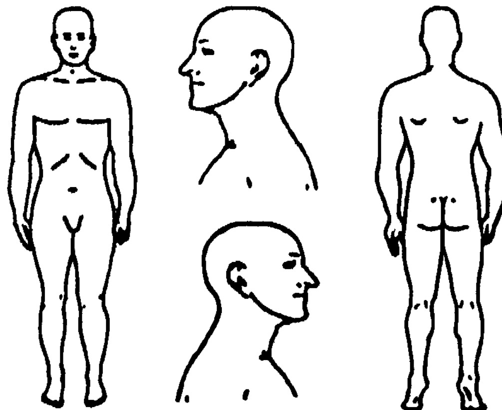
Psychiatric
- ☐ Memory loss
- ☐ Depression
- ☐ Anxiety

Genitourinary
- ☐ Pain with urination
- ☐ Blood in urine

Female Patients: Are you pregnant? ☐ Yes ☐ No

What is the reason for your visit today? Present Complaints: ____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Patient Signature: ____