PATIENT INFORMATION (CONFIDENTIAL)

Name: _____ Referred By: _____

Date of Birth: _____ Age: _____ Sex: Male_____ Female_____

Social Security Number: _____ Mobile Phone: _____Messages: Yes / No

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Marital Status (Circle): Single / Married / Divorced / Widowed / Separated Pregnant? Yes / No

Employer/Occupation: _____ Work Phone: _____

Spouse's Name: _____ No. of Children: _____

Emergency Contact: _____ Contact Phone: _____

PLEASE FILL IN THE APPROPRIATE SPACES: (All Information you provide is confidential)

What time of the day is the pain most aggravated? Morning____ Afternoon ____ Evening____

Does the pain wake you up at night or keep you awake? _____ is the pain constant? _____

What makes the pain BETTER (ie. Stretching, exercise, lying down)? _____

What makes it WORSE (ie. Sitting/Standing/walking ___ minutes)? _____

Date of Injury or Onset: _____

Chief Complaint: _____

_____

How did the condition begin? _____

Have you lost any work days: Yes_____ No_____ How many days? _____

Have you had this problem or similar problems in the past? _____

Does the pain travel from its site to anywhere else?_____

What kind of pain? Throbbing___ Aching___ Burning___ Dull achy___ Sharp___ Etc._____

When did you last see a chiropractor? _____

Medication(s) you are currently taking? _____

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FAMILY HISTORY:

Arthritis_____ Cancer_____ Diabetes_____ Heart Disease_____ Hypertension_____ Stroke_____

Other: _____

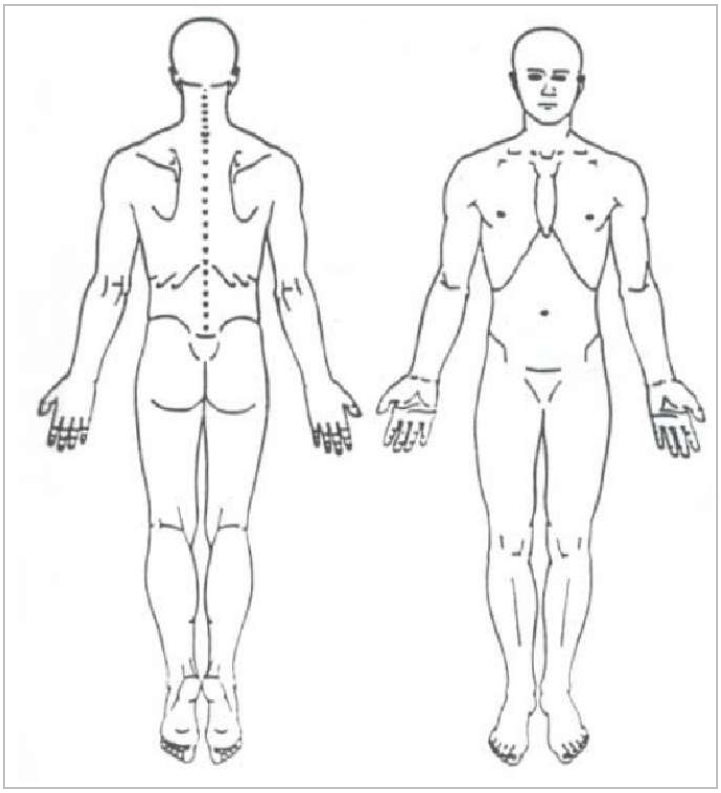
MARK PAST CONDITIONS WITH (X)

RATE PAIN FROM CURRENT CONDITIONS FROM 1-10

__Headache
__Dizziness
__Neck pain/stiffness
__Shoulder pain
__Upper or mid back pain
__Low back pain or stiffness
__Hip pain
__Numbness in toes
__Numbness in fingers
__Pins & needles in arms
__Pins & needles in legs
__Sleeping problems
__Depression
__Nervousness
__Head seems too heavy
__Chest pain
__Shortness of breath
__Fatigue
__Buzzing in ears
__Ringing in ears
__ Sensitive to light
__Loss of memory
__Face is flush
__Dizzy spells
__Loss of smell
__Loss of taste
__Diarrhea/Constipation
__Hands or feet get cold
__Upset stomach
__Cold sweat
__Fever
__Cancer
__Stroke
__High/low blood pressure
__HIV/AIDS
__Other_____
_____
_____
_____
_____

CIRCLE THE AREA YOU EXPERIENCE PAIN/DISCOMFORT

RATE PAIN 1-10



Patient Signature: _____ Date: _____

<u>TO BE COMPLETED BY DOCTOR:</u>

C0 C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 S (1, 2, 3, 4, 5) LtSI RtSI

<u>C-SP</u> F: *P* **LL:** *P* **LR:** *P* **<u>L-SP</u> F:** *P* **LL:** *P* **LR:** *P*
E: *P* **RL:** *P* **RR:** *P* **E:** *P* **RL:** *P* **RR:** *P*

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