

# WELCOME TO TLC CHIROPRACTIC

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 Last Name First Name Middle Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Sex: M F Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

Married  Widowed  Single  Minor  Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation: \_\_\_\_\_

Patient Employer/School: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_

Employer/School Phone: (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident: \_\_\_\_\_

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable)  
 \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

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

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

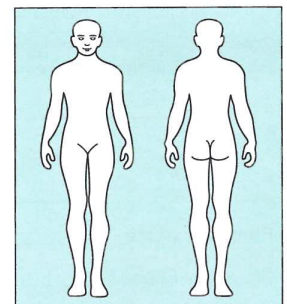
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                     |                              |                             |                     |                              |                             |                      |                              |                             |                              |                              |                             |
|---------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| AIDS/HIV            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine Headaches   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____                  |                              |                             |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |                              |                             |
| Chicken Pox         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |                              |                             |
|                     |                              |                             |                     |                              |                             | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                              |                              |                             |

## EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

## WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

## HABITS

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

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

_____ _____ _____ Pharmacy Name _____ Pharmacy Phone (____) _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
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