ACTIVE FAMILY Chiropractic

Patient Information Form

Account #_____

First Name:_____ Middle Initial:_____ Last Name:_____ DOB:____/____/_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ text? □ Y □ N Work Phone: (_____)_____-_____

Email address: _____ # of children:_____ Ages of children:_____

[CMS requires providers to report ethnicity and race] Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino Language:_____

Race: □ American Indian/Alaska Native □ Asian □ Black/ African American □ White/ Caucasian □ Native Hawaiian/ Pacific Islander □ Other

Gender: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed Name of Spouse:_____

Occupation: _____ Workplace:_____

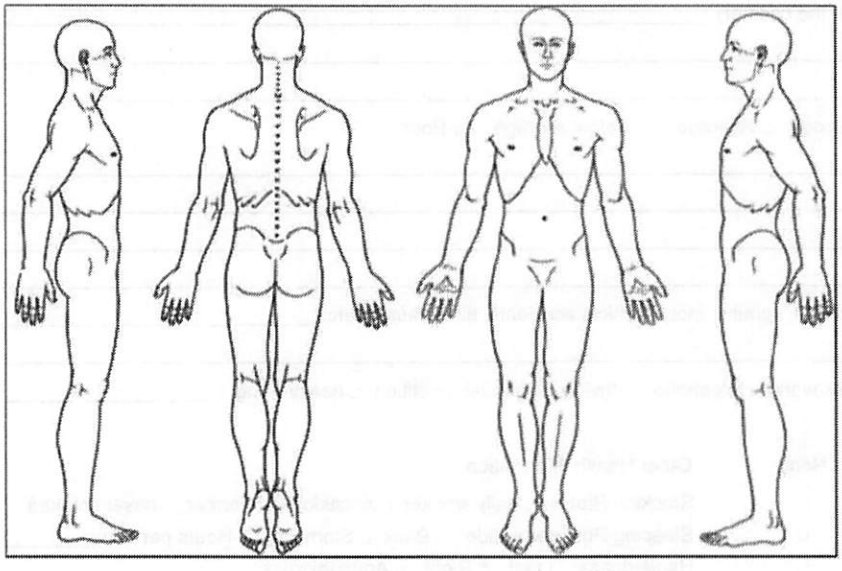
Emergency Contact:_____ Phone: (_____)_____-_____

How did you hear about us?_____

Describe the purpose of this appointment:_____

When did this condition begin?_____ Have you had similar conditions in the past?_____

Please indicate on diagram where you have symptoms:



Using a 0-10 scale (0 = no pain 10 = severe pain)

Neck Pain	_____/10
Mid Back Pain	_____/10
Low Back Pain	_____/10
_____	_____/10
_____	_____/10

What percentage of the day are your symptoms present?

Neck Pain	_____%
Mid Back Pain	_____%
Low Back Pain	_____%
_____	_____%
_____	_____%

Is this related to: □ Workers Compensation □ Motor Vehicle Accident □ Sports Injury □ Chronic Discomfort □ Repetition □ Stress □_____

Please explain:_____

Since it started has this condition: □ gotten worse □ stayed the same □ gotten better

Does this condition interfere with: □ work □ sleep □ daily routine □ sports □ caring for children □_____

What brings relief?_____ What aggravates it?_____

Have you seen any other health care providers for diagnosis or management of this condition? □ Y □ N Were x-rays taken? □ Y □ N

Practitioner's Name:_____ Care Received:_____

Have you seen a chiropractor in the past? □ Y □ N Chiropractor's Name:_____ Last treatment:_____

For Office Use Only: Height_____ Weight_____ BP Seated_____/_____ Pulse_____ BP Standing_____/_____ Pulse _____

My Health Conditions – Please check each of the diseases or conditions that are *current* or have had in the *past*.

- ◻ Allergy
- ◻ Convulsions
- ◻ Dizziness
- ◻ Fatigue
- ◻ Headache
- ◻ Loss of Sleep
- ◻ Loss of Weight
- ◻ Anxiety/Depression
- ◻ Numbness
- ◻ Cancer
- ◻ Diabetes
- ◻ Thyroid Problems
- ◻ Epilepsy
- ◻ Hyperactivity

- ◻ Arthritis
- ◻ Hernia
- ◻ Low Back Pain
- ◻ Neck Pain
- ◻ Midback Pain

Numbness or Pain in:

- ◻ Shoulders
- ◻ Upper arm
- ◻ Hands
- ◻ Legs
- ◻ Feet

- ◻ Poor Posture
- ◻ Swollen Joints
- ◻ Gout
- ◻ Polio

- ◻ Constipation
- ◻ Diarrhea
- ◻ Digestive Dysfunction
- ◻ Gallbladder issues
- ◻ Hemorrhoids
- ◻ Liver issues
- ◻ Ulcers
- ◻ Colitis

- ◻ Asthma
- ◻ Frequent Colds
- ◻ Muscular eye dysfunction
- ◻ Deafness
- ◻ Ear Infections
- ◻ Ringing in Ears
- ◻ Eye Pain
- ◻ Vision Problems
- ◻ Nasal Obstruction
- ◻ Sinus Infection

- ◻ High Blood Pressure
- ◻ Low Blood Pressure
- ◻ Poor Circulation
- ◻ Irregular Heartbeat
- ◻ Ankle Swelling
- ◻ Anemia
- ◻ Arteriosclerosis
- ◻ Heart Attack
- ◻ Stroke

- ◻ Chest Pain
- ◻ Chronic Cough
- ◻ Irregular breathing
- ◻ Wheezing
- ◻ Emphysema

- ◻ Bed-Wetting
- ◻ Painful Urination
- ◻ Prostrate Issues
- ◻ Blood in Urine
- ◻ Venereal Disease

Women only:

- ◻ Menstrual Cramps
- ◻ Excessive menstruation
- ◻ Irregular Cycle
- ◻ Hot Flashes
- ◻ Currently Pregnant

◻ Other (not listed)___ _____

Vitamins and supplements I take:_____

_____

Current list of medications and dosage (prescription and over the counter):_____

_____

Do you have any allergies to medications? ◻ Y ◻ N_____

How would you rate your overall health? ◻ Excellent ◻ Good ◻ Average ◻ Below average ◻ Poor

Family members with diagnosed health problems:_____

_____

Please list all past surgical procedures and dates:_____

_____

Please list all past physical trauma (falls, sports injuries, fractures, sprains, motor vehicle accidents, birth trauma, etc.)_____

_____

Primary daily activities: ◻ sitting ◻ standing ◻ walking ◻ desk work ◻ telephone ◻ driving ◻ manual repetition ◻ heavy lifting ◻_____

Health Habits:	Heavy	Moderate	Light	None
Tobacco	◻	◻	◻	◻
Coffee	◻	◻	◻	◻
Alcohol	◻	◻	◻	◻
Recreational Drugs	◻	◻	◻	◻
Prescription Drugs	◻	◻	◻	◻
Exercise	◻	◻	◻	◻
Sleep	◻	◻	◻	◻
Appetite	◻	◻	◻	◻
Present Stress	◻	◻	◻	◻
Past Stress	◻	◻	◻	◻

Other Health Information:

Smoking Status: ◻ daily smoker ◻ occasional ◻ former ◻ never smoked

Sleeping Posture: ◻ Side ◻ Back ◻ Stomach Hours per day:_____

Handedness: ◻ Left ◻ Right ◻ Ambidextrous

My goals for care:

- ◻ Relief Care – symptomatic relief of pain or discomfort
- ◻ Corrective Care – correcting and relieving the cause as well as symptoms
- ◻ Comprehensive Care – bring me to my highest state of health
- ◻ I would like the doctor to select the type of care appropriate for my health.

I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary. I have, to the best of my ability, thoroughly completed the information above. In the event that x-rays are necessary for my care, I understand that they will be the property of Active Family Chiropractic and will remain in the clinic where they can be reviewed by the doctors as needed. I choose to decline receipt of my clinical summary after every visit but am aware that it is available to me by request.

Signature of Patient/Guardian_____ Date____/____/_____