Jauch Chiropractic

1895 Eggert Road, Amherst, NY 14226
Phone: (716) 465-5567 Email contact@jauchchiro.com

Please Print

Patient Information

Name _____ Date_____
Date of Birth _____ Age_____ E-Mail Address_____
Street Address_____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone_____
Occupation_____
Employer _____ Business Phone _____
Sex: □ Male □ Female Height_____ Weight _____
Are you: □ Married □ Single □ Domestic Partnership □ Divorced □ Separated □ Widowed
Spouses Name: _____ # of Children_____
Emergency Contact Name _____ Relationship_____
Contact Phone _____
Do you have any special needs? _____
How did you hear about us? _____
Who is your primary care provider? _____
Address _____
Phone _____

Present Health

Please describe your current problem._____
_____
_____
How did your problem begin? _____
_____
_____
Date problem began_____
How often are your symptoms present? ___Constantly ___Frequently ___Occasionally
Since it began, is your problem: ___Improving ___Getting worse ___No change
What makes the problem better? ___Nothing ___Walking ___Exercise
___Sitting ___Standing ___Lying down ___Other_____
What makes the problem worse? ___Nothing ___Walking ___Exercise
___Sitting ___Standing ___Lying down ___Other_____
Describe your job requirements: ___Mainly sitting ___Light labor ___Heavy labor
Can you perform your daily work activities? ___Yes, all activities ___Only some ___Not at all
Describe your stress level: ___None to mild ___Moderate ___High
Describe your current exercise regimen _____
_____
What do you do for personal relaxation, special interest, or hobbies? _____
_____

Jauch Chiropractic

1895 Eggert Road, Amherst, NY 14226
Phone: (716) 465-5567 Email contact@jauchchiro.com

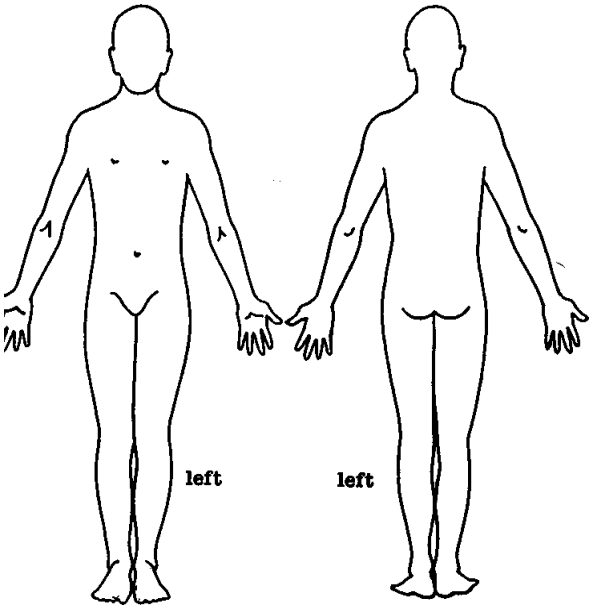
Medical History

Have you ever been treated by a: □ Chiropractor □ Naturopathic Doctor
□ Reflexology □ Massage Therapist
□ Acupuncturist □ Other alternative practitioner _____
_____

Personal History

As a child, did you have any of the following diseases?
□ Scarlet fever □ Rheumatic fever □ Diphtheria □ Mumps □ Measles □ German measles
□ Other _____
List hospitalizations or surgeries have you had with corresponding dates.
_____
_____
Have you ever been in an auto accident? _____ When? _____
List other injuries including falls and other traumas and when they occurred:
_____
_____
_____
Please list any allergies you may have _____
_____
Please list any medications or supplements you are currently taking _____
_____
_____

Please mark an X on the picture where you have pain or any other symptoms. To the right of the picture, please describe these symptoms.



_____
_____
_____
_____

What is the level or intensity of pain you are currently experiencing?

(Circle a number)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

To what extent does pain limit your daily activity?

(Circle a number)

(No effect) 0 1 2 3 4 5 6 7 8 9 10 (Incapable of activity)

I hereby authorize the practitioners to perform the procedures necessary to facilitate my diagnosis and treatment:

Patients Signature_____ **Date**_____