Wright Life Chiropractic

PATIENT INFORMATION

1. First Name: _____ Last Name: _____

   Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

2. Street Address: _____ Apt/Unit #: _____

   City: _____ State: _____ Zip: _____

3. Cell Phone: _____ Home Phone: _____ Work Phone: _____

   Email: _____

   What is your preferred method of communication?
   ☐ Phone ☐ Text ☐ Email

4. Emergency Contact: _____ Relationship: _____

   Phone: _____

5. Are you Medicare eligible?
   ☐ Yes ☐ No

6. Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)?
   ☐ Yes ☐ No

7. How did you hear about Wright Life Chiropractic?

   _____

8. If you were referred by someone, please tell us who so we may thank them.

   _____

   (Patient or Legal Guardian Signature) _____ (Date) _____

PATIENT HISTORY

9. Name _____ Age _____ Date of Birth _____ Gender ☐ Male ☐ Female

Height _____ Weight _____ Occupation _____ For how long? _____

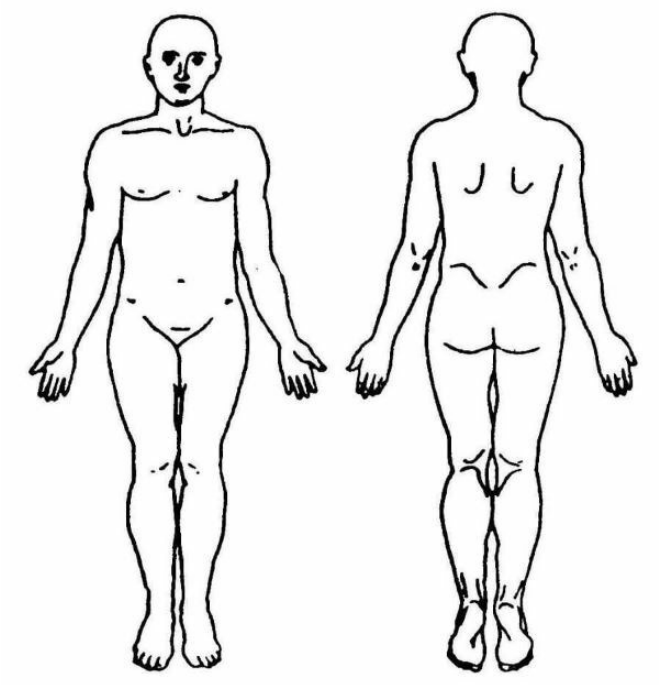
10. Have you had chiropractic care before? ☐ Yes ☐ No
If yes, how recently? _____

11. Reason for today's visit:
☐ Pain ☐ Discomfort ☐ Stiffness ☐ Maintenance ☐ Recent Injury ☐ Previous Injury ☐ Other

12. When did the complaint(s) begin? _____
Today, is the condition: ☐ Same ☐ Better ☐ Worse

13. Explain what helps your condition: _____
Explain what worsens your condition: _____

14. **On the body diagrams below, please indicate your areas of symptoms by drawing in the appropriate symbols. P - pain N - numbness T - tingling W - weakness R - radiating A - aching S - sharp**



15. On a scale of 1 to 10, with 1 being none and 10 being the most severe, how would you rate your pain at its worst?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

16. On a scale of 1 to 10, with 1 being none and 10 being the most severe, how would you rate your pain today?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

17. How often do you feel this pain/discomfort?
☐ Constant ☐ Off and On ☐ Occasionally

18. Have you experienced this/these complaint(s) before?
☐ Yes ☐ No
If yes, when?
_____

19. Have you seen any other provider for this condition?
☐ Yes ☐ No
If yes, who have you seen and when?
_____

20. Are you pregnant?
☐ Yes ☐ No
If yes, how many weeks?
_____

21. Are you currently experiencing any of the following:
☐ Nausea or vomiting ☐ Rapid eye movement ☐ Numbness on one side of the face or body
☐ Fainting or lightheadedness ☐ Dizziness ☐ Difficulty walking ☐ Difficulty speaking
☐ Headache or neck pain ☐ Difficulty swallowing ☐ Double vision

(If yes to any, please describe)

_____

22. Current prescriptions or over-the-counter medications?

_____

23. PAST HISTORY: MUSCULOSKELETAL CONDITIONS(please check all that apply)
☐ Headaches/Migraines ☐ Neck Pain/Discomfort
☐ Shoulder Pain/Discomfort ☐ Elbow Pain/Discomfort
☐ Wrist Pain/Discomfort ☐ Upper Back Pain/Discomfort
☐ Middle Back Pain/Discomfort ☐ Low Back Pain/Discomfort
☐ Hip Pain/Discomfort ☐ Knee Pain/Discomfort
☐ Ankle Pain/Discomfort ☐ Sciatica ☐ Herniated Disc
☐ Fused/Fixated Joints ☐ Joint Replacement ☐ Arthritis
☐ Osteoporosis ☐ Osteopenia
☐ Inflammation/Swelling: where_____

OTHER CONDITIONS:
☐ Cancer ☐ Heart Disease
☐ Tumors ☐ Aids/HIV ☐ Stroke
☐ Diabetes ☐ Seizure Disorder
☐ Hepatitis
☐ High Blood Pressure
☐ Tuberculosis ☐ Pacemaker
☐ Hernia ☐ Allergies
☐ Other_____

24. Indicate if you have experienced any of the following.
☐ Surgeries? ☐ Yes ☐ No ☐ Accidents/Broken Bones? ☐ Yes ☐ No ☐ Hospitalization? ☐ Yes ☐ No

(If yes to any, list and describe)

_____

25. Family Health History: (check all that apply)
☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

WORK, SOCIAL, HABITS

26. Current work habits - Choose all that apply.

☐ Permanently full disabled ☐ Permanently partially disabled ☐ Cannot work due to current condition
☐ Full-time (32-40+hours/week) ☐ Part-time (1-32 hours/week) ☐ Retired ☐ Student ☐ Homemaker
☐ Unemployed

27. Personal Social Habits

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

28. Present exercise habits

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		

29. CHIROPRACTIC ACTIVITY ASSESSMENT

DID YOU KNOW:	YES	NO
The absence of pain is not an indication of health?		
Pain has a cause and many times that cause begins in the spine?		
Over-the-counter pain medications and/or prescriptions may only mask the pain?		
Your daily activities can cause joint pain and dysfunctions in the spine and extremities?		
These joint dysfunctions can cause decreased joint motion and function in the body?		
Decreased joint motion can also affect your ability to enjoy a healthy and active lifestyle?		
The health benefits of routine chiropractic care may include any of the following: 1)Improved nerve communication 2) Improved joint motion 3) Improved joint coordination 4) Improved physical function 5) Improved physical performance 6) Improved posture 7) Increased daily activity 8) Provide pain and stress relief		

30. (Patient or Legal Guardian Signature) (Date)