Name:____ Date:________________________

CONFIDENTIAL PATIENT INFORMATION

Phone: H:__________________ W:__________________ C:__________________ E-Mail: ________________________________
If we need to contact you regarding your case, which phone numbers would you prefer we use? Any Home Work Cell
Address:____ City:________________________ State:_____ Zip:__________
Age:______ Birth Date:_____/_____/_____ Sex: M F Marital Status: M S W D How many children?______ages:__________
Occupation:___________________________ Employer:___________________________ Social Security No.:________________________
Name of Spouse: _______________ Occupation:__________________ Name/No. of Emergency Contact:___________________________

Who can we thank for referring you to our office?____

Do you *have*, or *have you* ever experienced:

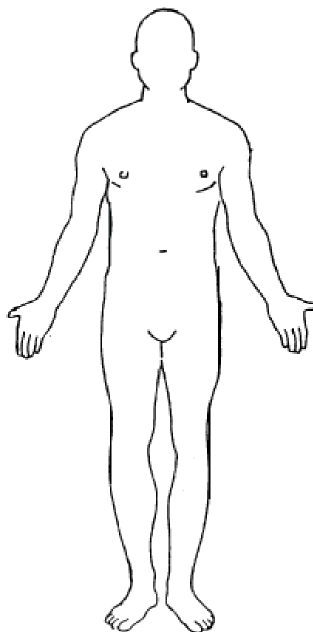
		Current Past Never
1.	Cancer	_________
2.	Heart Trouble/Disease	_________
3.	Stroke	_________
4.	High/Low Blood Pressure	_________
5.	Diabetes	_________
6.	Chest Pain	_________
7.	Asthma	_________
8.	Shortness of Breath	_________
9.	Dizziness/Fainting Spells	_________
10.	Digestive Disorders	_________
11.	Bladder Problems	_________
12.	Thyroid Disorder	_________
13.	Reproductive Concerns	_________
14.	Frequent Colds/Flues	_________
15.	Sinus Problems/Allergies	_________
16.	Depression	_________
17.	Nervousness	_________
18.	Seizures	_________
19.	Uncontrollable Shaking	_________
20.	Trouble Concentrating	_________
21.	Trouble Sleeping	_________
22.	Arthritis	_________
23.	Osteoporosis	_________
24.	Fatigue/Lack of Energy	_________
25.	Headaches	_________
26.	Neck Pain	_________
27.	Mid Back Pain	_________
28.	Low Back Pain	_________
29.	Arm or Hand Pain	_________
30.	Leg or Foot Pain	_________
31.	Other:______________	_________

Indicate what is currently bothering you:

Put **P** where you have **Pain** Put **S** where you are **Sore**
Put **SW** were you are **Swollen** Put **N** where you are **Numb**

<u>Front of Body</u>

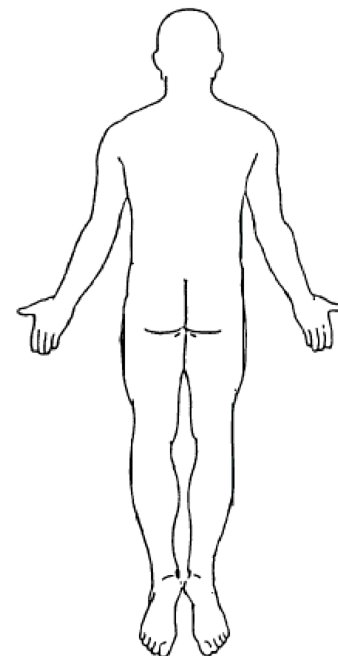
Right Left



Numbness
Pins and Needles
00000
Burning
xxxxx
Stabbing
//////
Ache
^^^^

<u>Back of Body</u>

Left Right



How do you want us to handle your problem?
______Temporary Relief (Help the symptom, but do not fix the cause of the problem)
______Maximum Correction (Correct the cause of the problem for maximum stability in the future)

Why did you come into our clinic and what are your expectations of us?____

What are your favorite hobbies and activities to do now?____
Are your current problems affecting these activities or hobbies? **Y N** explain:____________________________________
What activities are you looking forward to doing in retirement?____
Who would you like to be doing these activities with?____

On a scale from 1-10 (10 being the most, 1 being the least)
_______ How committed are you at being at your maximum health potential?
_______ How important is it for your family to be at their optimum health potential?
_______ How committed are you to preventing arthritis and maximizing your spinal stability?

What is your **Major Complaint**?____

Have you seen any other **Health Care Providers** for your current condition(s)? **Y N** (If yes, please list)

Date:________ Who:________________ Where: ________________ Treatment rendered: ____________________
Date:________ Who:________________ Where: ________________ Treatment rendered: ____________________

When was your last **Physical Exam** or **Check-Up**? Date: ________ Doctor: ________________Where: ________________
Do you have a current **Medical Doctor**? **Y N** Name:________________Address:________________________

Have you ever been to a **CHIROPRACTOR** before? **Y N** Date: ________ Doctor(s): ______________Where: ____________

What conditions were you seen for? ____
Were you helped by previous chiropractic care? **Y N** Why are you changing chiropractors?________________________

Please list all **Motor Vehicle Accidents** that you have been involved in:

Date:________ Type: rollover, head-on, broad sided, rear-ended, other:____________________________
Any injuries? **Y N** List:____________________ Any treatment? **Y N** List:____________________
Date:________ Type: rollover, head-on, broad sided, rear-ended, other:____________________________
Any injuries? **Y N** List:____________________ Any treatment? **Y N** List:____________________
Date:________ Type: rollover, head-on, broad sided, rear-ended, other:____________________________
Any injuries? **Y N** List:____________________ Any treatment? **Y N** List:____________________

Please list any previous **Trauma**, falls, concussions, contact sports, abuse, and/or any broken bones that you have had (please include dates):

Please list any previous **Surgeries** that you have had (please include dates):____________________________

Please list any **Medications** that you are currently taking and what condition they are for:____________________

Please circle **Tests** that you have had done before: X-rays, CTscan, MRI, Blood Work, Bone Density Test, Nerve Conduction Tests
Other tests and dates of each:____

Women: Are you **Pregnant** or **think** that you may be pregnant? **Y N** **please initial:______**
Do you experience irregular menstrual cycles? **Y N**
Do you experience painful periods (cramps, back pain, headaches)? **Y N**

Family History: Who in your family has or had:

Cancer:__________________ Diabetes:__________________ Multiple Sclerosis:________________
Heart Disease:________________ High Blood Pressure:________________ Stroke:__________________
Back Pain:__________________ Headaches:__________________ Other:__________________

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Name of person responsible for Payment:________________________________
Are you insured? **Yes** **No** Company: ________________________________

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Patient's Signature:________________________________ Date:________________

Guardian or Spouse's Signature:____________________________ Date:________________