

CONFIDENTIAL PATIENT INFORMATION: (Please Print)

TODAYS DATE ___/___/___

Full Name: _____ Home Ph#: _____ Cell/Pager: _____
Last First M.I.
Address _____ City _____ Zip Code _____
Age _____ Birth Date ___/___/___ SS# _____ - _____ Status: M S W D No. of children _____
Drivers License Number _____
Occupation: _____ Employer: _____ Work Phone: _____

In Event of an emergency, who should we contact? _____ Relation _____
Home Ph#: _____ - _____ - _____ Work Ph#: _____ - _____ - _____ Your Medical Doctor _____

INSURED INFO: (Primary Policy Holder)

(If same as patient information please skip to next section)

Name _____ Birth Date: ___/___/___ SS#: _____ - _____
Occupation _____ Employer _____ Relation _____

How were you referred to this office?

- Friend, (who?) _____ Family, (who?) _____
 Phone Book?: SBC Yellow Book, Doctor, (who?) _____
 Location/Signage Internet Other: _____

HEALTH HISTORY:

Have you been treated by a chiropractor before? No Yes

If yes, what chiropractor(s): _____ Were X-rays taken? No Yes
Last time treated: _____ For what complaint: _____

Have you been treated by any other physicians in the past 2 years? No Yes

If yes, for what: _____
List any previous surgeries with dates: _____

List any past accidents with dates: _____

List any vitamins or minerals you are presently taking: _____

List any medications being taken for your **present complaint**: _____

Have the medications helped decrease your discomfort? No Yes Temporarily

List prescription medications being taken for other health conditions: _____

List anything you are allergic to: _____

Do you smoke? No Yes, If yes, how much? _____ For how long? _____

Are you wearing: Heel Lifts Sole Inserts Arch Supports Custom Made Orthotics None

Women Only:

Are you taking birth control? No Yes

Are you pregnant? No Yes, If yes how far along? _____

Have you ever had any of the following diseases/medical conditions?:

Y/N Frequent Neck Pain	Y/N Severe/Frequent Headaches	Y/N Dizziness
Y/N Numbness/Tingling	Y/N Ear Infections	Y/N Sinus Infections
Y/N Low Back Pain	Y/N Sciatica	Y/N Diabetes
Y/N Heart Attack/Stroke	Y/N Congenital Heart Defect	Y/N Alcohol/Drug Abuse
Y/N HIV+/Aids	Y/N Hepatitis	Y/N Shingles
Y/N Cancer	Y/N Emphysema/Glaucoma	Y/N Anemia
Y/N High/Low Blood	Y/N Kidney Problems	Y/N Ulcers/Colitis
Y/N Asthma	Y/N Sinus Problems	Y/N Arthritis
Y/N Difficulty Breathing	Y/N Difficult Digestion	Y/N Bed-wetting
Y/N Fainting/Seizures	Y/N Swollen Joints	Y/N Bruise Easily

PRESENT COMPLAINT INFORMATION:

Is your complaint due to a work related injury or automobile accident?: No Yes

If yes, has the case been settled with the insurance company?: No Yes

Purpose for this appointment, what is your chief complaint(s)? _____

What caused your complaint(s)?: _____

When did your symptoms first appear?: _____

How frequent are your symptoms?: Continuous Comes & Goes Daily

Has your complaint(s)?: Improved Gotten Worse Not Changed, since the onset?

Which of the following best describe your pain: Sharp Dull Aching Burning Stabbing Numb
Tingling Throbbing Other: _____

Do your symptoms radiate to another area?: No Yes, If yes, where? _____

What activities/positions **increase** your discomfort?: _____

What activities/positions **decrease** your discomfort?: _____

Have you had this or other spinal complaint(s) before?: No Yes, If yes when?: _____

Have you received any previous treatment from another physician for this complaint?: No Yes
If yes, who: _____

Have you done anything at home to treat your complaint? (cold pack, heat, etc.) No Yes
If yes, what: _____

Do you experience any other symptoms or health problems at this time?: No Yes, If yes what?: _____

Do you have a history of any family health problems?: No Yes, If yes what?: _____

PATIENT SIGNATURE: _____ DATE: ____/____/____

GAURDIAN OR SPOUSES SIGNATURE AUTHORIZING CARE: _____