

**Patient Data****Date:** \_\_\_\_\_**Title:**  Mr.  Mrs.  Ms  Miss (check one)**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_**Address Line 1:** \_\_\_\_\_**Address Line 2:** \_\_\_\_\_**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_**Cell Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:**  Male  Female **Email:** \_\_\_\_\_**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status:**  Single  Married  Other**Employment Status:**  Employed  Full Time Student  Part Time Student  Other (check one)**Spouse Data****Is your spouse a patient in the clinic?**  Yes  No**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_**Employer Data****Name:** \_\_\_\_\_**Address Line 1:** \_\_\_\_\_**Address Line 2:** \_\_\_\_\_**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_**Emergency Contact****Contact Name:** \_\_\_\_\_**Contact Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Is it okay to call you at work?**

- Yes  No

**How did you hear about our clinic? Or who referred you?**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney         | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class   |
| <input type="checkbox"/> Friend        | <input type="checkbox"/> Yellow Pages     | <input type="checkbox"/> Billboard         | <input type="checkbox"/> Brochure       |
| <input type="checkbox"/> Physician     | <input type="checkbox"/> Newspaper ad     | <input type="checkbox"/> TV Commercial     | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer      | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio             | <input type="checkbox"/> Other          |

**If you selected 'Yellow Pages' please indicate which Yellow Pages:**

**If you selected 'family member', 'friend', or 'physician' please enter their name below:**

**If you selected 'other' please describe**

**Medical Conditions:**

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke        |

**Surgeries:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy                   |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies            | <input type="checkbox"/> Radical prostatectomy   | <input type="checkbox"/> Transurethral prostate surgery |

**Allergies:**

- |                               |   |  |                                 |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy  | <input type="checkbox"/> Sulfites           | <input type="checkbox"/> Wheat/Gluten    |                                 |

**Social History:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally   | <input type="checkbox"/> Caffeine used often            | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often           |
| <input type="checkbox"/> Drink alcohol occasionally   | <input type="checkbox"/> Drink alcohol often            | <input type="checkbox"/> Exercise not at all       | <input type="checkbox"/> Exercise occasionally        |
| <input type="checkbox"/> Exercise often               | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often   | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always         | <input type="checkbox"/> Wear seat belts never     | <input type="checkbox"/> Wear seatbelts usually       |

**Family History:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent)      | <input type="checkbox"/> Arthritis (sibling)      | <input type="checkbox"/> Cancer (parent)              | <input type="checkbox"/> Cancer (sibling)              |
| <input type="checkbox"/> Cholesterol (parent)    | <input type="checkbox"/> Cholesterol (sibling)    | <input type="checkbox"/> Diabetes (parent)            | <input type="checkbox"/> Diabetes (sibling)            |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent)    | <input type="checkbox"/> Psychiatric (sibling)    | <input type="checkbox"/> Stroke (parent)              | <input type="checkbox"/> Stroke (sibling)              |
| <input type="checkbox"/> Thyroid (parent)        | <input type="checkbox"/> Thyroid (sibling)        |   |  |

**Substance Use:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past)      | <input type="checkbox"/> Alcohol (present)      | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past)      | <input type="checkbox"/> Cocaine (present)      |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past)       | <input type="checkbox"/> Heroin (Present)       |
| <input type="checkbox"/> Marijuana (past)    | <input type="checkbox"/> Marijuana (present)    |  |   |

**Male Children:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

**Female Children:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

**Occupational Activities:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner           | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user         |
| <input type="checkbox"/> Construction   | <input type="checkbox"/> Daycare/childcare        | <input type="checkbox"/> Executive/legal      | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care    | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor   | <input type="checkbox"/> Home services         |
| <input type="checkbox"/> Household      | <input type="checkbox"/> Light manual labor       | <input type="checkbox"/> Manufacturing        | <input type="checkbox"/> Medium manual labor   |

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

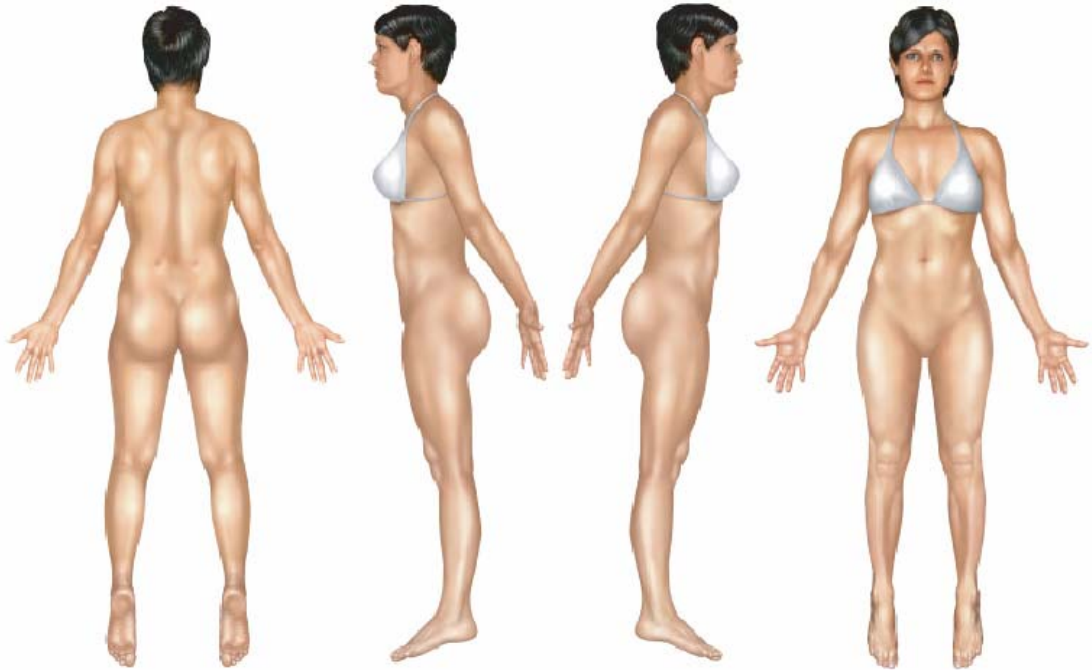
# = Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache



Describe your symptoms: \_\_\_\_\_

When did your symptoms start? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

**How often do you experience your symptoms?**

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

**What describes the nature of your symptoms?**

- Sharp
- Burning
- Dull ache
- Tingling
- Numb
- Stabbing
- Shooting

**How are your symptoms changing?**

- Getting better
- Not changing
- Getting worse

**During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)**

- 0 None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Unbearable

**During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

**During the past 4 weeks, how much of the time has your condition interfered with your social activities?**

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

**In general, would you say your overall health right now is....**

- Excellent                       Very good                       Good                       Fair  
 Poor

**Who have you seen for your symptoms:**

- No one                       Other Chiropractor                       Medical Doctor                       Physical Therapist  
 Other

**What treatment did you receive for your symptoms?**

- Adjustments                       Physical Therapy                       Medication                       Surgery  
 Other

**When did you receive this treatment?**

- In the last month                       2 – 3 months ago                       3 – 6 months ago                       6 months to 1 year ago  
 1 – 2 years ago                       2 – 5 years ago                       5 – 10 years ago

**What tests have you had for your symptoms?**

- X-rays                       MRI                       CT Scan                       Other

**When were these tests done?**

- In the last month                       2 – 3 months ago                       3 – 6 months ago                       6 months to 1 year ago  
 1 - 2 years ago                       2 – 5 years ago                       5 – 10 years ago

**Have you had similar symptoms in the past?**

- Yes                       No

**If you have seen treatment in the past for the same or similar symptoms, who did you see?**

- This Office                       Other Chiropractor                       Medical Doctor                       Physical Therapist  
 Other

**What is your occupation?**

- Professional/Executive                       White Collar/Secretarial                       Tradesperson                       Laborer  
 Homemaker                       Full-time Student                       Retired                       Other

**If you are not retired, a homemaker or a student, what is your work status?**

- Full-time                       Part-time                       Self-employed                       Unemployed  
 Off work                       Other

**Thank you. Please return to the front desk.**