Patient Data:

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one) **Date:** _______________
First Name: _________________ **Middle Initial:** ______ **Last Name:** _________________
Address_____________________ **City:** _____________ **State:** ______**Zip Code:** _________
Home Phone: (_____) _______-___________**Cell Phone:** (_____) ________-___________
Work Phone: (_____) _______-___________**Email:** _________________________________
Date of Birth: _____/_____/_____ **Social Security Number:** _________-_____-____________
Marital Status: ☐Single ☐Married ☐Other
Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other

Spouse Data:

Is your spouse a patient in the clinic? ☐Yes ☐ No
First Name: __________________ **Middle Initial:** _____ **Last Name:** _________________
Home Phone: (_____) ________-____________ **Work Phone:** (_____) ________-__________

Employer Data:

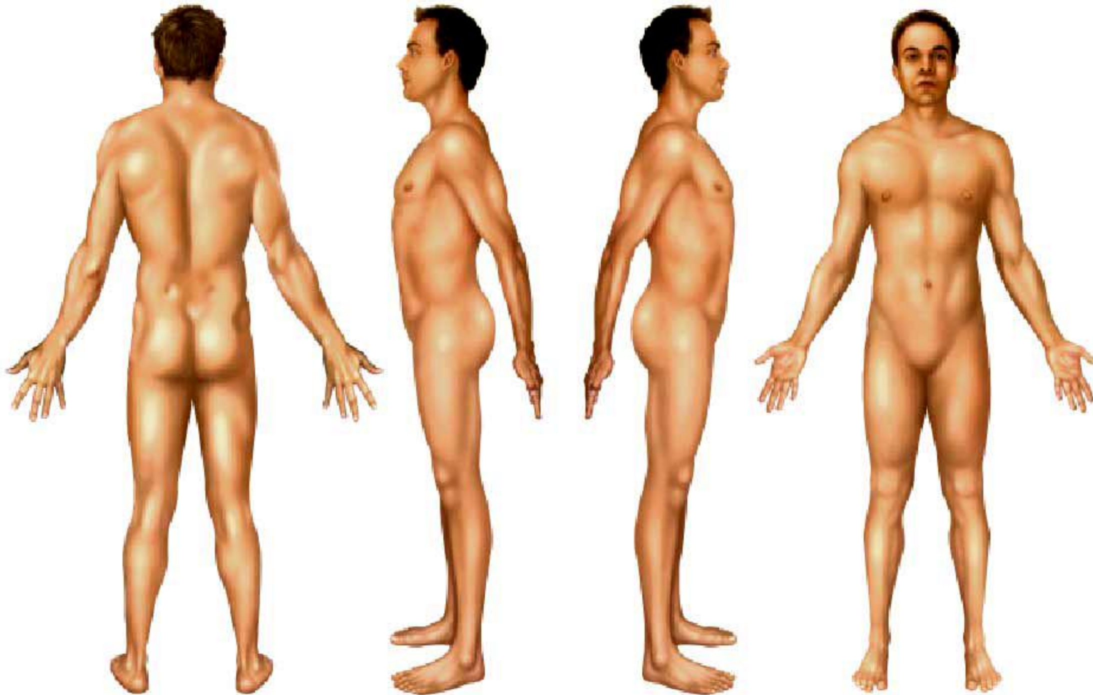
Name: ________________________ **Address** _____________________________________
City: ___________________________ **State:** _______________ **Zip Code:** ____________

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?
☐ Family member __________________ ☐ Web site ☐ Health class ☐ Friend__________________ ☐ Yellow Pages
☐ Brochure ☐ Physician ☐ Newspaper ☐ Direct mail ☐ Sign on building ☐ Radio ☐ Other ______________________
Medical Conditions:
☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐ Stroke
☐ Other ____
Surgeries:
☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical disc procedure ☐ Hysterectomy ☐ Joint replacement
☐ Laminectomy ☐ Radical prostatectomy ☐ Transurethral prostate surgery ☐ Other________________________
Allergies:
☐ Eggs ☐ Fish and Shellfish ☐ Milk or Lactose ☐ Peanut ☐ Soy ☐ Sulfites ☐ Wheat/Gluten ☐ Other ______________
Social History:
☐ Caffeine used occasionally ☐ Caffeine used often ☐ Drink alcohol occasionally ☐ Drink alcohol often
☐ Exercise not at all ☐ Exercise occasionally ☐ Exercise often ☐ Experience stress occasionally
☐ Experience stress often ☐ Tobacco use occasionally ☐ Tobacco use often ☐ Tobacco use not at all
☐ Wear seat belts always ☐ Wear seat belts never ☐ Wear seatbelts usually
Family History:
☐ Arthritis (parent) ☐ Arthritis (sibling) ☐ Cancer (parent) ☐ Cancer (sibling) ☐ Cholesterol (parent) ☐Cholesterol (sibling) ☐ Diabetes (parent) ☐ Diabetes (sibling) ☐ Heart problems (parent) ☐ Heart problems (sibling) ☐ High blood pressure (parent) ☐ High blood pressure (sibling) ☐ Psychiatric (parent) ☐ Psychiatric (sibling) ☐ Stroke (parent) ☐ Stroke (sibling) ☐ Thyroid (parent) ☐ Thyroid (sibling) ☐ Other ____
Substance Use:
☐ Alcohol (past) ☐ Alcohol (present) ☐ Amphetamines (past) ☐ Amphetamines (present) ☐ Barbiturates (past)
☐ Barbiturates (present) ☐ Cocaine (past) ☐ Cocaine (present) ☐ Crystal Meth (past) ☐ Crystal Meth (present)
☐ Heroin (past) ☐ Heroin (Present) ☐ Marijuana (past) ☐ Marijuana (present) ☐ Other _________________________
Male Children:
☐ Under 6 years ☐ Under 10 years ☐ Under 19 years
Female Children:
☐ Under 6 years ☐ Under 10 years ☐ Under 19 years
Occupational Activities:
☐ Administration ☐ Business owner ☐ Clerical/secretarial ☐ Computer user ☐ Construction ☐ Daycare/childcare
☐ Executive/legal ☐ Food service industry ☐ Health care ☐ Heavy equipment operator ☐ Heavy manual labor
☐ Home services ☐ Household ☐ Light manual labor ☐ Manufacturing ☐ Medium manual labor ☐ Military ☐ Police/fire
☐ Professional Service ☐ Teacher ☐ Truck driver ☐ 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 ______________________________
Recreational Activities:
☐ Biking ☐ Football☐ Golf ☐ Running ☐ Skiing ☐ Swimming ☐ Walking ☐ Weight lifting Other __________________

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?
□ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26-50%) □ Intermittent (0-25%)
What describes the nature of your symptoms?
□ Sharp □ Dull ache □ Numb □ Shooting □ Burning □ Tingling □ Stabbing
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 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 Unbearable
During the past 4 weeks, how much has pain interfered with your normal daily activity?
□ 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 socially?
□ 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 – 6 months ago □ 6 months to 1 year ago □ 1 – 5 years ago □ More than 5 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 – 6 months ago □ 6 months to 1 year ago□ 1 - 5 years ago □ More than 5 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 _________________________

Thank you. Please return to the front desk.