



Patient Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work _____ Cell _____

E-mail Address _____

Birthdate _____ Age _____ Sex: M F Married/Single/Widowed/Divorced

Number of Children _____ Referred to this Office By _____

If a Minor (under 18 years old), name and address of responsible parent/guardian:

Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work _____ Cell _____

*****EMPLOYMENT INFORMATION*****

Employer _____ Occupation/Title _____

Employer Address/Phone _____

City _____ State _____ ZIP _____

*****INSURANCE INFORMATION*****

Insurance Carrier _____ Insured's name _____

Relationship to Insured – Self / Husband / Wife / Child / Other _____

Member ID # _____ Group # _____

Carrier Contact Phone # _____

*****EMERGENCY CONTACT INFORMATION*****

Name of Emergency Contact _____ Relationship _____

Home Phone _____ Work _____ Cell _____

*****CHIEF COMPLAINT*****

Current Condition/Problem_____

Any radiating symptoms? What/Where?_____

When did this condition occur? _____

Please describe what happened:_____

Since onset Is the condition getting: Better Worse Same

Anything similar ever happened before? If yes explain: _____

Is Condition: ____ Job Related ____ Auto Related ____ Home Injury ____ Fall ____ Other

Other Doctors seen for this condition: Yes No Who? _____

Type of Treatment_____ Results_____

Last Chiropractor seen_____

Have you been treated for any health conditions in the last year? Y N If yes, please explain_____

*****PAST HEALTH*****

Other Conditions (current/past)_____

Surgeries_____

Fractures/Broken Bones_____

Major Trauma/Car Accidents_____

Medications/Supplements_____

Last Doctor Seen_____

Last Physical_____

Xrays/MRI/CT_____

*****FAMILY HISTORY*****

Please list family members affected by the following:

Cancer_____

Diabetes_____

Heart Disease_____

Osteoporosis_____

Genetic Diseases_____

Please UNDERLINE conditions you have had PREVIOUSLY and CIRCLE conditions you have NOW

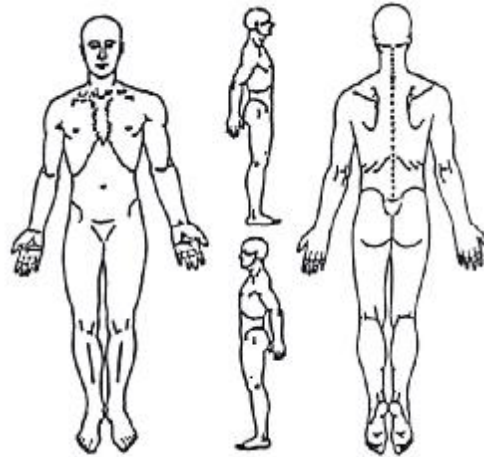
DIABETES
 LOW BACK PAIN
 ARM PAIN
 NUMBNESS
 DIZZINESS
 FAINTING
 ALLERGIES
 HEADACHES
 LOSS OF CONSCIOUSNESS

CANCER
 PAIN BETWEEN SHOULDERS
 JOINT PAIN/STIFFNESS
 PARALYSIS
 FORGETFULNESS
 CONVULSIONS
 LOSS OF SLEEP
 SINUS TROUBLE
 ARTHRITIS

HEART DISEASE
 NECK PAIN
 WALKING PROBLEMS
 DIFFICULTY CHEWING/CLICKING JAW
 CONFUSION/DEPRESSION
 COLD/TINGLING EXTREMITIES
 FEVER
 DIGESTIVE DISTURBANCES
 OSTEOPOROSIS

Mark the exact location of your symptoms on the diagram:

A = Ache
 P = Pins & Needles
 B = Burning
 S = Stabbing
 N = Numbness
 O = Other



Comments:

Please indicate how your pain affects you in the six categories of daily living listed below. PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. "0" signifies that your pain does NOT affect your activity level and "10" signifies that ALL activities in which you would normally be involved have been disrupted or prevented by your pain.

1. Completing Family/Home Responsibilities. Ex. Chores and duties around the house (laundry) and errands or favors for other family members (driving the kids to school).
 0 1 2 3 4 5 6 7 8 9 10
2. Recreation. Ex. Hobbies, sports, and other similar leisure time activities.
 0 1 2 3 4 5 6 7 8 9 10
3. Social Activity. Ex. Activities which involve participation with friends and acquaintances other than family members (parties, theater, concerts, dining out, and other social functions).
 0 1 2 3 4 5 6 7 8 9 10
4. Occupation. Ex. Activities that are part of or directly related to your job. This also includes non-paying jobs such as volunteer work.
 0 1 2 3 4 5 6 7 8 9 10
5. Self Care. Ex. Activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)
 0 1 2 3 4 5 6 7 8 9 10
6. Life-Support Activity. Activities which support basic life behaviors (eating, sleeping, and breathing).
 0 1 2 3 4 5 6 7 8 9 10