Welcome to Our Clinic

Today's Date
_/ _/

1. Patient Information (Please Print)

Name_____
First Last MI

Address_____

City State Zip

Sex ☐ M ☐ F Date of Birth___/___/___ Age_____

Single Married Widowed ☐Separated ☐Divorced

SSN ☐☐☐-☐☐-☐☐☐☐

Occupation_____ Full Time Part Time

Employer _____Phone_____

Employer Address_____

Spouse's Name_____
Date of Birth ___/__/___ SSN_____

2. Phone Numbers

Home _____Work _____Ext____

Cell _____Other_____

E-mail Address_____
Whom should we contact in case of emergency?
Name _____

Relationship_____
Cell /
Home_____Work_____

3. Financial Information none

Person Responsible for this Account:

_____

Relationship to Patient _____ Self

Insurance Information: None

Company_____

I.D. Number _____Group_____

Phone Number_____

Subscriber's Name_____

Date of Birth___/___/___ Relationship _____

Additional Insurance None

Insurance Company_____

I.D. Number _____Group_____

Phone Number_____

Subscriber's Name_____

Date of Birth___/___/___ Relationship _____

4. Accident Information

Is Condition Due to an Accident? Yes No

Type of Accident: Auto Work Home Other

To Whom Have You Made a Report of your Accident?

Auto Insurance Employer Work Comp Other

5. Patient Condition – your main complaint…)1*

Reason for Today's Visit_____Date Started__/__/___

Do You Know What May Have caused this?_____

Is Your Pain/Discomfort: Dull Sharp Burning Tingling Throbbing Numbness Stabbing

And is it: Mild Moderate Severe Pain Scale (circle one): Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

How often do you suffer from this? ☐Daily __Times Per Week __Times Per Month __Times Per Year How long does it last? _____ And Is It: Intermittent Frequent Constant What makes it better? _____ What makes it worse? _____

Does it interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Walking Bending ☐Standing itting

What have you tried to relieve your symptoms?_____

6.Past, Family and Social History -

Patient Name:

a) Past Health History:

Do you have any of the following? Please check Yes or No for each condition.

Relative Contraindications:

Absolute Contraindications:

Articular Hypermobility Disease Yes No

Demineralization of Bone Yes No

Tumor (Spine) Yes No

Yes No Dislocation(s)_____

No Unstable OS Odontoedeum

Malignancies that involve the vertebral column

of bones or joints of the vertebral column Yes No

Yes No

Upper Extremities Yes No

Lower Extremities Yes No

Rheumatoid Arthritis Yes No Severe

Ankylosing Spondylitis. Yes No Benign Bone

Fracture(s) _____ Yes No Bleeding Disorder

Yes No Are You Taking Anti Coagulant Therapy? Yes

Yes No **Radiculopathy with**

Yes No Infection

Progressive Neurological Signs:

Radiating Pain, Numbness, or Weakness Myelopathy

Cauda Equina Syndrome. Yes No

Vertebrobasilar Insufficiency Syndrome. Yes No

Major Artery Aneurysm Yes No

Previous Major Illnesses/Injuries _____

Operations, Hospitalizations, Surgeries _____

Medications you are currently taking:

☐ High Blood Pressure _____ ☐ Cholesterol_____ ☐ Pain_____ ☐ Arthritis_____

☐ Depression_____ ☐ Anxiety_____ ☐ ADD/ADHD_____ ☐ Insulin _____

☐ Other _____

b) Family History – Immediate Family (Mother, Father, Siblings, Children):

Health Status of Family Members _____

Are there any immediate family members that suffer from:

Stroke Heart Attack Cancer Tumor Degenerative Disk Disease Arthritis Osteoporosis

Other _____

If any of the above items are checked, then, whom in your family? _____

Are there any other diseases that are "hereditary" or seem to "run in your family"? _____

c) Social History –

Please tell the Doctor about your activities:

Exercise:	Work/ School	Habits: None	Education:
None	Sitting	Smoking-Packs Per Day_____ None	Drugs_____ None High School
Occasional	Standing	Alcohol - Times Per Week_____ None	Some College
Daily	Light Labor	Caffeine; Coffee, Sodas, Tea… Cups Per Day_____ None	College Grad
Weekly	Heavy Labor	Hobbies_____ None	Post Grad

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with State statutes.

Patient Signature_____ Date____/____/____

I have reviewed Form. Doctor's Signature_____ Date____/____/____