

DATE: _____



CHART NO.: _____

PATIENT INFORMATION					
FULL NAME	DATE OF BIRTH	SEX	AGE	SSN	
ADDRESS	CITY		STATE	ZIP	
HOME PHONE	WORK PHONE		CELL PHONE		
EMAIL			MARITAL STATUS: SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		
EMPLOYER			OCCUPATION		
SPOUSE NAME		DATE OF BIRTH		SSN	
REFERRED BY <input type="checkbox"/> FRIEND <input type="checkbox"/> SPEAKING ENGAGEMENT <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> YELLOW PAGES					
EMERGENCY CONTACT		RELATION		PHONE	

PATIENT COMPLAINTS:

DATE SYMPTOM(S) BEGAN: _____

HOW WOULD YOU RATE YOUR OVERALL PAIN TODAY, WHERE 0 IS NO PAIN AND 10 IS THE WORST PAIN:

0 1 2 3 4 5 6 7 8 9 10

Description → Numbness Pins & Needles Burning Aching Stabbing
 Symbol → NNNN PPPP BBBB AAAA SSSS

Circle any areas not represented by a symbol

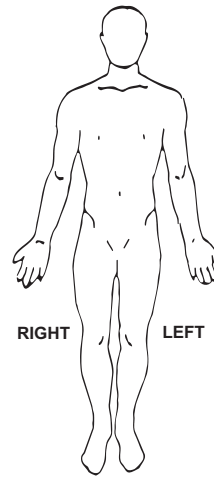
PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS SHOWN IN THE EXAMPLE BELOW. MARK ALL AREAS WITH THE APPROPRIATE SYMBOL(S).



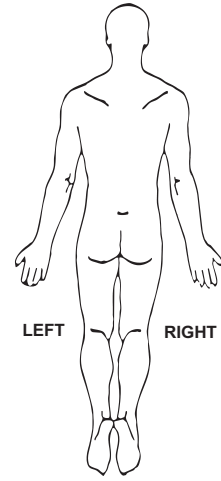
EXAMPLE



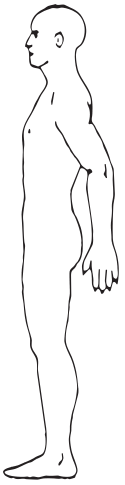
RIGHT



FRONT



BACK



LEFT

SYMPTOM(S):

CONDITIONS OR ILLNESS:

- HEART ATTACK STROKE HIGH BLOOD PRESSURE DIABETES PACEMAKER ARTIFICIAL BONES/JOINTS _____
 CANCER ASTHMA THYROID WEIGHT LOSS WEIGHT GAIN HEADACHES EPILEPSY KIDNEY PROBLEMS INDIGESTION
 WHEN ARE YOUR SYMPTOM(S) WORSE? MORNING AFTERNOON EVENING NIGHT ALWAYS STAY THE SAME
 WHAT MAKES YOUR CONDITION BETTER? NOTHING REST HEAT ICE STRETCHING EXERCISE MEDICATIONS STANDING SITTING
 WHAT MAKES YOUR CONDITION WORSE? NOTHING SNEEZING COUGHING BENDING LIFTING SITTING WALKING STANDING

FAMILY HISTORY:

	CANCER	DIABETES	HEART TROUBLE	HIGH BLOOD PRESSURE	STROKE	KIDNEY DISEASE	ANEMIA	MENTAL ILLNESS	HEADACHES	OSTEOPOROSIS	ARTHRITIS	JOINT PROBLEMS	SCROLIOSIS	BACK PROBLEMS	DISC PROBLEMS	CONGENITAL DEFECTS	GENETIC DISEASE	OTHER	DECEASED?
FATHER																			
MOTHER																			
BROTHERS																			
SISTERS																			
CHILDEN																			

DESCRIBE OTHERS:

NAME: _____

DATE: _____

CHART NO.: _____



MEDICAL HISTORY:

LIST ALL SURGERIES AND DATES: _____

HAVE YOU EVER HAD A SERIOUS ACCIDENT/INJURY? YES NO

WORK RELATED AUTO ACC. SPORT INJURY PERSONAL INJURY

LIST DATES AND DESCRIBE INJURIES: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS YES NO

PLEASE LIST ALL MEDICATIONS: _____

ARE YOU CURRENTLY TAKING ANY VITAMINS, MINERALS OR HERBS? YES NO PLEASE LIST: _____

PLEASE LIST ANYTHING YOU MAY BE ALLERGIC TO: _____

ARE YOU PREGNANT? YES NO

HAVE YOU EVER BEEN TO A CHIROPRACTOR? YES NO IF SO, WHEN AND WHOM DID YOU SEE? _____

DO YOU HAVE A FAMILY PHYSICIAN? YES NO IF SO, PLEASE STATE PHYSICIANS NAME AND DATE LAST SEEN.

HABITS/ACTIVITIES:

SMOKING NEVER < 1 PACK/DAY 1-2 PACKS/DAY 2-3 PACKS/DAY

CAFFEINATED DRINKS NEVER < 1 GLASS/DAY 1-2 GLASSES/DAY 2-3 GLASSES/DAY MORE THAN 3 GLASSES/DAY

ALCOHOL CONSUMPTION NEVER < 1 GLASS/DAY 1-2 GLASSES/DAY 2-3 GLASSES/DAY MORE THAN 3 GLASSES/DAY

EXERCISE NEVER < 1 DAY/WEEK 1-2 DAYS/WEEK 2-3 DAYS/WEEK 3-4 DAYS/WEEK +5 DAYS/WEEK

KINDS OF EXERCISE _____

OCCUPATIONAL INFORMATION:

WHAT IS YOUR OCCUPATION? _____

HOW MANY HOURS DO YOU WORK PER WEEK? _____

WHAT IS YOUR PRIMARY WORK POSITION AND LOCATION?

SEATED STANDING DESK

WHAT MOVEMENTS DOES YOUR JOB REQUIRE?

BENDING TWISTING CARRYING TURNING WALKING STOOPING TYPING

DOES YOUR WORK INCLUDE ANY OF THE FOLLOWING USE?

PROLONGED COMPUTER CONTINUOUS PHONE

DOES YOUR JOB INVOLVE LIFTING?

NEVER OCCASIONALLY INTERMITTENTLY FREQUENTLY CONSTANTLY HOW MANY LBS. _____

DO WORK ACTIVITIES AGGRAVATE YOUR PRESENT CONDITION? _____

AUTHORIZATIONS:

The undersigned agrees to and understands all information of this agreement. I accept financial responsibility for services given regardless of insurance reimbursement to provider. Our policy requires payment in full for all service rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

I hereby consent to the performance of examination and treatment on me by the licensed doctors of chiropractic, certified therapy assistants and any other technical support staff who may be employed or engaged in practice in this clinic. I understand that while very small, there are certain degrees of risk associated with chiropractic care and with any and all supportive physical therapeutic modalities. These risks include, but are not limited to fractures, disc injury, stroke, sprains, strains and soreness. I am therefore willing to accept and consent to the risks associated with the care I am about to receive.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE PATIENT GUARDIAN

DATE