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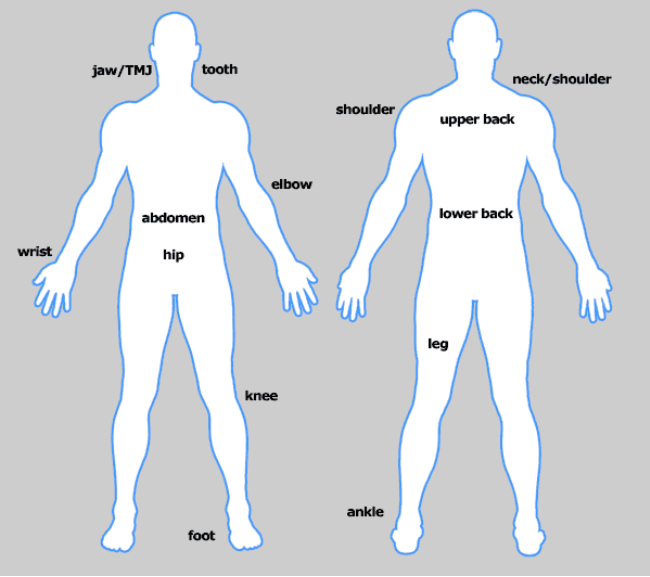
PATIENT INFORMATION FORM

	TODAY'S DATE:		DATE OF BIRTH:
NAME:	☐ MALE ☐FEMALE	AGE:	☐MARRIED ☐SINGLE ☐WIDOWED ☐DIVORCED ☐SEPARATED ☐_____
ADDRESS:	CITY:		STATE: ZIP:
HOME PHONE:	CELL:		FAX:
SOCIAL SECURITY #:	DRIVER'S LICENSE:	STATE:	EMAIL ADDRESS:
SPOUSE'S NAME:	AGES OF CHILDREN:		OCCUPATION/JOB TITLE:
EMPLOYER/BUSINESS NAME:	BUSINESS ADDRESS:		
BUSINESS PHONE:	TYPE OF WORK:		
HOW DID YOU HEAR ABOUT US?			
EMERGENCY CONTACT:			PHONE #:

INSURANCE

ADDRESS:			RELATIONSHIP:
WHO IS RESPONSIBLE FOR YOUR BILL?	☐SELF ☐WORKER'S COMP	☐AUTO INSURANCE MEDICARE	☐MEDICAID ☐OTHER (BE SPECIFIC):
PERSONAL HEALTH INSURANCE CARRIER:			HEALTH ID CARD #:
INSURED PERSON'S NAME:			PRIMARY CARE PHYSICIAN:
INSURED PERSON'S SOCIAL SECURITY #:			PHARMACY:

CURRENT HEALTH CONDITION



PLEASE CIRCLE AREAS OF DISCOMFORT

CHIEF COMPLAINT: (WHY ARE YOU HERE TODAY?)

BODY AREA INVOLVED:	☐CERVICAL (NECK) ☐SPINE (MID-BACK), RIBS, PELVIS (LOW BACK)			☐UPPER EXTREMITY (ARMS, WRIST, HANDS) ☐LOWER EXTREMITY (LEGS, FEET, TOES)		
CONDITION:	☐NEW ☐RECURRING			☐EXACERBATION ☐CHRONIC		
MECHANISM OF ONSET:	☐AUTO ☐WORK	☐FALL ☐LIFTING	☐OVER EXERTION ☐REPETITIVE MOTION	☐UNKNOWN ☐SLEPT WRONG	☐SLIP OR FALL ☐NO INJURY	☐OTHER
SYMPTOMS:	☐PAIN ☐NUMBNESS	☐STIFFNESS ☐WEAKNESS				
LOCATION:	☐LEFT ☐RIGHT	☐BILATERAL				
QUALITY:	☐BURNING ☐DIFFUSE	☐DULL/ACHING ☐LOCALIZED	☐SHARP ☐SHOOTING	☐STABBING ☐THROBBING	☐TIGHTNESS ☐TINGLING	☐RADIATING ☐OTHER

ON A SCALE OF 0-10, (10 BEING THE WORST) RATE YOUR SYMPTOMS (RESTING):	0	1	2	3	4	5	6	7	8	9	10
ON A SCALE OF 0-10, (10 BEING THE WORST) RATE YOUR SYMPTOMS (WITH ACTIVITY):	0	1	2	3	4	5	6	7	8	9	10

DURATION: SYMPTOM(S) STARTED:

SYMPTOM(S) WORSENED:

SYMPTOM(S) LAST OCCURRED:

SYMPTOM(S) LAST EPISODE:

INJURY OCCURRED:

ACCIDENT OCCURRED:

TIMING WORSE IN THE: ☐MORNING ☐AFTERNOON ☐NIGHT ☐W/ACTIVITY ☐CONSTANT ☐ INTERMITTENT

ASSOCIATED SIGNS & SYMPTOMS:
☐BLURRED ☐VISION ☐DEPRESSION ☐DIZZINESS
☐HEADACHES ☐IRRITABILITY/MOOD SWING ☐LOCALIZED TINGLING
☐NAUSEA ☐RADIATING ☐RINGING IN EARS
☐SLEEP ☐DISTURBANCE ☐STIFFNESS

QUALITY OF HEADACHES:
☐ DULL ☐ SHARP
☐THROBBING ☐STABBING
☐AURA ☐NO AURA
☐RADIATION: ☐LEFT ☐RIGHT ☐BILATERAL
☐WEAKNESS: ☐LEFT ☐RIGHT ☐BILATERAL

OTHER ASSOC. SIGNS & SYMPTOMS:
☐ACHES ☐COLD LIMB ☐DIZZINESS ☐FATIGUE
☐FEVER ☐HEARTBURN ☐MUSCLE SPASM ☐NAUSEA
☐NUMBNESS ☐PALE BLUISH SKIN ☐PANIC ☐PINS & NEEDLES
☐RUNNY NOSE ☐STIFFNESS ☐SWEATING ☐SWELLING
☐TINGLING ☐VOMITING ☐WEAKNESS

MODIFYING FACTORS – SYMPTOMS BETTER WITH:
☐ACTIVITY ☐BENDING ☐COLD ☐HEAT ☐MASSAGE ☒MOVEMENT ☐OTC MEDS ☐RX MEDS ☐REST ☐STRETCHING ☐SITTING ☐STANDING ☐TWISTING ☐WALKING ☐NOTHING HELPS

SINCE CONDITION BEGAN, HAS ANYTHING PERMANENTLY HELPED YOU?
☐YES ☐NO

HAS ANYTHING THAT YOU HAVE DONE, THUS FAR, FIXED YOUR PROBLEM
☐YES ☐NO

EMPLOYMENT

OCCUPATION:

WORK (HRS/DAY):

JOB CLASSIFICATION: ☐SITTING ☐LIGHT ☐MODERATE ☐HEAVY LIFTING

LIFTING FREQUENCY: ☐CONSTANT (66-100% DAY) ☐FREQUENT (33-65% DAY) ☐OCCASIONAL (0-32% DAY)

WORK ACTIVITY POSTURES: (HRS/DAY)
☐SITTING ☐STANDING ☐WALKING ☐CLIMBING ☐PUSHING ☐PULLING ☐KNEELING ☐REACHING ☐TWISTING ☐BENDING

REPETITIVE ACTIVITIES: (HRS/DAY)
☐COMPUTER ☐PHONE ☐MACHINERY ☐HAND TOOLS ☐ASSEMBLY ☐GRASPING

HOW DOES THIS CONDITION EFFECT JOB PERFORMANCE:
☐MILD PAINFUL (CAN DO) ☐MODERATE PAINFUL (LIMITED) ☐SEVERE (UNABLE TO PERFORM) ☐OTHER (EXPLAIN)

DAILY ACTIVITIES: ON A SCALE OF 0-10, TO WHAT LEVEL ARE YOU EXPERIENCING SYMPTOMS WHILE PERFORMING THESE ACTIVITIES											
ACTIVITY (CHECK APPLICABLE COLUMN)	**0 NO EFFECT**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 UNABLE TO DO**
BENDING:											
CARE –INFIRM FAMILY:											
CARRYING GROCERIES:											
CHANGE POS.–SIT-STAND:											
CLIMB STAIRS:											
DRIVING:											
EXTENDED COMPUTER USE:											
FEEDING:											
HOUSEHOLD CHORES:											
KNEELING:											
LIFT CHILDREN:											
LIFTING:											
PET CARE:											
READING (CONCENTRATION):											
SELF CARE:											
SELF CARE–BATHING:											
SELF CARE–DRESSING:											
SELF CARE–SHAVING:											
SEXUAL ACTIVITIES:											
SLEEP:											
STATIC SITTING:											
STATIC STANDING:											
WALKING:											
YARD WORK:											

BELOW IS A LIST OF DISEASES THAT MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT.
HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.
REVIEW OF SYMPTOMS – PLEASE FILL OUT ALL OF THE SECTIONS, EVEN IF "DENY"

CONSTITUTIONAL: ☐I DENY ANY CONST. ISSUE(S)	☐CHILLS ☐NIGHT SWEATS	☐WEIGHT GAIN ☐WEIGHT LOSS	☐FATIGUE ☐FEVER	☐DAYTIME SOMNOLENCE (DROWSINESS)			
EYE/VISION: ☐I DENY ANY EYE/VISION ISSUE(S)	☐BLINDNESS ☐DOUBLE VISION	☐EYE PAIN ☐PHOTOPHOBIA	☐TEARING ☐BLURRED VISION	☐FIELD CUTS (VISUAL FIELD DEFECT)	☐CATARACTS ☐GLAUCOMA	☐CHANGE IN VISION ☐ITCHING (AROUND EYES)	☐WEAR GLASSES AND/OR ☐CONTACT LENSES
EARS, NOSE, & THROAT: ☐I DENY ANY E/N/T ISSUE(S)	☐BLEEDING ☐DISCHARGE ☐DIZZINESS ☐SNORING	☐FAINTING ☐HEADACHES ☐LOSS OF SMELL ☐SORE THROATS (FREQUENT)	☐NASAL CONGESTION ☐SINUS INFECTIONS ☐DENTAL IMPLANTS	☐EAR DRAINAGE ☐EAR INFECTION(S) ☐HEARING LOSS ☐TINNITUS (RIGHT IN EARS)	☐POST NASAL DRIP ☐DIFFICULTY SWALLOWING ☐EAR PAIN	☐HOARSENESS ☐RHINORRHEA (RUNNY NOSE) ☐SINUS INFECTIONS ☐TMJ PROBLEMS	
RESPIRATION: ☐I DENY ANY RESPIRATORY ISSUE(S)	☐ASTHMA	☐COUGHING UP BLOOD	☐SPUTUM PRODUCTION	☐COUGH	☐SHORTNESS OF BREATH	☐WHEEZING	
CARDIOVASCULAR: ☐I DENY ANY CARDIO. ISSUE(S)	☐ANGINA (CHEST PAIN OR DISCOMFORT) ☐CHEST PAIN ☐CLAUDICATION (LEG PAIN OR ACHINESS)	☐HEART MURMUR ☐HEART PROBLEMS ☐ORTHOPNEA (DIFFICULTY BREATHING WHILE LYING DOWN)	☐PALPITATIONS (IRREGULAR OR FORCEFUL BREATHING OF THE HEART) ☐PAROXYSMAL NOCTURNAL DYSPNEA (WAKING AT NIGHT WITH SHORTNESS OF BREATH)	☐SWELLING OF LEGS ☐ULCERS ☐VARICOSE VEINS			
GASTROINTESTINAL: ☐I DENY ANY GI ISSUE(S)	☐ABDOMINAL PAIN ☐BELCHING ☐BLACK, TARRY STOOLS ☐CONSTIPATION	☐DIARRHEA ☐DIFFICULTY SWALLOWING ☐HEARTBURN ☐HEMORRHOIDS	☐INDIGESTION ☐JAUNDICE (YELLOWING OF SKIN) ☐NAUSEA ☐RECTAL BLEEDING	☐ABNORMAL STOOL CALIBER (QUALITY) ☐ABNORMAL STOOL COLOR ☐ABNORMAL STOOL CONSISTENCY	☐VOMITING BLOOD ☐VOMITING		

FEMALE: ☐I DENY ANY FEMALE ISSUE(S)	☐BIRTH CONTROL THERAPY ☐BREAST LUMP/PAIN ☐BURNING URINATION	☐CRAMPS ☐FREQUENT URINATION ☐HORMONE THERAPY	☐IRREGULAR MENSTRUATION ☐URINE RETENTION ☐VAGINAL BLEEDING	☐VAGINAL DISCHARGE	
MALE: ☐I DENY ANY MALE ISSUE(S)	☐BURNING URINATION ☐PROSTATE PROBLEMS	☐ERECTILE DYSFUNCTION	☐FREQUENT URINATION ☐URINATION RETENTION	☐HESITANCY/DRIBBLING	
ENDOCRINE: ☐I DENY ANY ENDOCRINE ISSUE(S)	☐COLD INTOLERANCE ☐DIABETES	☐EXCESSIVE APPETITE ☐EXCESSIVE HUNGER	☐EXCESSIVE THIRST ☐FREQUENT URINATION	☐GOITER ☐HAIR LOSS	☐HEAT INTOLERANCE ☐UNUSUAL HAIR GROWTH ☐VOICE CHANGES
SKIN: ☐I DENY ANY SKIN ISSUE(S)	☐CHANGES IN NAIL TEXTURE ☐CHANGES IN SKIN COLOR	☐HAIR GROWTH ☐HAIR LOSS	☐HIVES ☐ITCHING	☐PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING)	☐RASH ☐HISTORY OF SKIN DISORDERS ☐SKIN LESIONS /ULCERS ☐VARICOSITIES
NERVOUS SYSTEMS: ☐I DENY ANY NS ISSUE(S)	☐DIZZINESS ☐FACIAL WEAKNESS	☐HEADACHES ☐LIMB WEAKNESS	☐LOSS OF CONSCIOUSNESS ☐LOSS OF MEMORY	☐NUMBNESS ☐SEIZURES	☐SLEEP DISTURBANCE ☐STRESS ☐STROKES ☐TREMORS ☐ UNSTEADINESS OF GAIT
PSYCHOLOGICAL: ☐I DENY ANY PSYCHOLOGICAL ISSUE(S)	☐ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE)	☐ANXIETY ☐APPETITE CHANGES	☐BEHAVIORAL CHANGE(S) ☐BIPOLAR DISORDER	☐CONFUSION ☐CONVULSIONS	☐DEPRESSION ☐INSOMNIA ☐MEMORY LOSS ☐MOOD CHANGES
ALLERGY: ☐I DENY ANY ALLERGY ISSUE(S)	☐ANAPHYLAXIS (HISTORY OF SNEEZING)	☐FOOD INTOLERANCE	☐ITCHING ☐NASAL CONGESTION	☐SNEEZING	
HEMATOLOGY: ☐I DENY ANY HEMATOLOGY ISSUE(S)	☐ANEMIA ☐BLEEDING	☐BLOOD CLOTTING ☐BLOOD TRANSFUSION(S)	☐BRUISES EASILY ☐FATIGUE	☐LYMPH NODE SWELLING	

PAST HEALTH HISTORY – PLEASE FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

CHILDHOOD ILLNESS: ☐I DENY ANY CHILDHOOD ILLNESS(ES)	☐ADD ☐ALLERGIES/HAYFEVER ☐ASTHMA ☐ATOPIC DERMATITIS (ECZEMA)	☐BED WETTING ☐CEREBRAL PALSY ☐CHICKEN POX ☐DEPRESSION	☐DIABETES ☐EAR INFECTIONS ☐FETAL DRUG ☐EXPOSURE	☐FOOD ALLERGIES ☐HEADACHES ☐HEPATITIS ☐HIV	☐MEASLES ☐MUMPS ☐RASH ☐SCOLIOSIS	☐SEIZURE DISORDER ☐SICKLE CELL ANEMIA ☐SPINA BIFIDA ☐OTHER (PLEASE DESCRIBE)
ADULT ILLNESS:☐I DENY ANY ADULT ILLNESS(ES)	☐ALZHEIMERS ☐ANEMIA ☐ARTHRITIS ☐ASTHMA ☐CANCER ☐CHICKEN BOX ☐CHRON'S/COLITIS ☐CRPS (RSD)	☐CVA (STROKE) ☐CYSTIC KIDNEY DISEASE ☐DEPRESSION ☐DIABETES (INSULIN) ☐DIABETES (NON INSULIN) ☐EAR INFECTIONS (FREQUENT) ☐EMPHYSEMA ☐EYE PROBLEMS	☐FIBROMYALGIA ☐HEART DISEASE ☐HEPATITIS ☐HIV ☐HYPERTENSION ☐INFLUENZA PNEUMONIA ☐LIVER DISEASE ☐LUNG DISEASE	☐LUPUS ERYTHEMA (DISCOID) ☐LUPUS ERYTHEMA (SYSTEMIC) ☐MULTIPLE SCLEROSIS ☐PARKINSON'S DISEASE ☐PLEURISY ☐PNEUMONIA ☐PSYCHIATRIC PROBLEMS ☐SCOLIOSIS	☐SEIZURE DISORDER ☐SHINGLES ☐STD'S (UNSPECIFIED) ☐SUICIDE ATTEMPT(S) ☐THYROID PROBLEMS ☐VERTIGO ☐PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION	
	☐OTHER _____					
SURGERIES:☐I DENY ANY SURGERY (IES)	☐ANGIOPLASTY ☐APPENDECTOMY ☐CAESAREAN SECTION ☐CARDIAC CATHETERIZATION ☐CARPAL TUNNEL REPAIR	☐CORONARY ARTERY BYPASS ☐COSMETIC ☐D & C ☐DENTAL SURGERY ☐GALL BLADDER	☐HEMORRHOIDECTOMY ☐HERNIA REPAIR ☐HYSTERECTOMY ☐JOINT RECONSTRUCTION ☐JOINT REPLACEMENT	☐LAMINECTOMY ☐MASTECTOMY ☐PACEMAKER INSERTION ☐ROTATOR CUFF ☐SPINAL FUSION	☐TONSILLECTOMY ☐OTHER	
OB/GYN:☐I DENY ANY OB/GYN ISSUES	☐I HAVE NEVER BEEN PREGNANT ☐I HAVE BEEN PREGNANT IN THE PAST ☐I AM CURRENTLY PREGNANT	**MENSTRUAL HISTORY:** AGE OF ONSET _____	☐MY MENSES IS REGULAR ☐MY MENSES IS IRREGULAR ☐I AM CURRENTLY IN MENOPAUSE	DATE OF LAST MENSES ___/___/___		
INJURIES:☐I DENY ANY INJURY (IES)	☐BACK INJURY ☐BROKEN BONES ☐SEVERE FALL	☐FRACTURE ☐DISABILITY ☐HEAD INJURY	☐INDUSTRIAL ACCIDENT ☐JOINT INJURY ☐SEVERE LACERATION	☐MOTOR VEHICLE ACCIDENT ☐MILD/MODERATE SOFT TISSUE INJURY ☐SEVERE SOFT TISSUE INJURY		
IMMUNIZATIONS: ☐I DENY ANY IMMUNIZATION(S)	☐DTAP (DIPTHERIA, TETANUS & PERTUSSIS)	☐FLU ☐HEPATITIS A ☐HEPATITIS B	☐HEPATITIS C ☐INFLUENZA ☐IPV (POLIO)	☐MMR (MEASLES, MUMPS, & RUBELLA) ☐PNEUMOCOCCAL ☐PPD (MANTOUX TEST-TB)	☐SMALL POX ☐TB ☐VARIVAX (CHICKEN POX)	☐WHOPPING COUGH (PERTUSSIS)
NON-DRUG ALLERGIES: ☐I DENY ANY NON-DRUG ALLERGIES	☐ANIMALS	☐DAIRY	☐EGGS	☐FOOD COLORING	☐MOLD	☐POLLEN

PREVIOUS TREATMENT

PREVIOUS CHIROPRACTIC CARE?	☐YES IF YES, WHO? (NAME) ☐NO		
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?	☐YES IF YES, WHO? (NAME) ☐NO	LOCATION OF OFFICE:	TYPE OF TREATMENT:
WERE YOU SASTIFIED WITH THE RESULTS OF YOUR TREATMENT?	☐YES EXPLAIN: ☐NO		
ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS?	☐YES IF YES, PLEASE MARK OR LIST (BE SPECIFIC) ☐NO	☐ALLERGY MEDICATION ☐ANTI-DEPRESSANTS	☐BLOOD PRESSURE MEDS. ☐INSULIN ☐MUSCLE RELAXERS ☐NERVE PILLS ☐PAIN KILLERS ☐OTHER (PLEASE SPECIFY)
DO YOU WEAR ANY OF THE FOLLOWING?	☐HEAL LIFTS ☐INNER SOLES	☐ARCH SUPPORTS ☐ORTHOTICS	PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT – EVEN IF UNRELATED

FAMILY HISTORY – ENTER INITIALS BELOW: A = ALIVE D = DECEASED

___ GENERAL FAMILY ___ FATHER ___ MOTHER ___ PATERNAL GRANDFATHER ___ PATERNAL GRANDMOTHER ___ MATERNAL GRANDFATHER ___ MATERNAL GRANDMOTHER ___ SON(S) ___ DAUGHTER(S) ___ BROTHER(S) ___ SISTER(S)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

SOCIAL HISTORY

ALCOHOL: ☐NEVER ☐DAILY ☐WEEKLY ☐MONTHLY ☐SOCIAL CONSUMPTION ONLY	☐BEER OZ.'S # GLASSES ☐LIQOUR ☐WINE	**DIET:** MARK ALL THAT APPLY ☐HIGH FAT ☐HIGH FIBER ☐HIGH PROTEIN ☐HIGH SALT ☐ LOW CALORIE ☐ LOW CARB ☐ LOW SUGAR ☐ LOW FIBER ☐ LOW SALT	
DRUGS: ☐ DENY ANY ILLEGAL DRUG USE ☐ DENY USE OF IV DRUGS	☐ HAVE NOT USED DRUGS SINCE _____ ☐ HAVE USED DRUGS FOR _____	**TOBACCO:** ☐ DENY TOBACCO USE ☐ LIVE W/A SMOKER ☐ QUIT SMOKING # PER: ___ ☐ DAY ☐ WEEK ☐ MONTH	☐ # CHEW ____

PLEAE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that chiropractic clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to chiropractic clinic will be credited to my account upon receipt. However I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

GUARDIAN OR SPOUSE'S SIGNATURE OF AUTHORIZING CARE: (SIGNATURE INDICATES CONSENT TO TREAT)		**DATE:**
PATIENT (PRINT NAME):	**PATIENT'S SIGNATURE:**	**DATE:**