Confidential Patient Information

Patient Name: ____ Date of Birth: _____________________

Address: _____________________________ City/State: _________________________ Zip Code: __________

Home Phone: _________________________ Email: ____________________________________

Cell Phone: __________________________ Occupation: ________________________________

Circle Preferred Contact Method: **Home** # or **Cell #**

Insurance Carrier: ____

Policy Holder Name: ___________________________________ Policy Holder Date of Birth: ___________________

Circle one: Self Spouse Parent

Emergency Contact: ____

Name Phone Relationship

Primary Care Physician: _________________________________ Phone: __________________________

When warranted, do we have permission to send your health information to your primary care provider? **Y / N**

Signature: ____ Date: __________

Health History

Have you ever been under Chiropractic Care? **Y / N** Chiropractor Name: ______________________________

Recent Diagnostic Tests (where / when):

Spinal X-ray**:** _________________________________ MRI: ___________________________________

CT Scan: ___________________________________ DEXA: __________________________________

EMG/NCV: __________________________________

Prior Injuries (year / area of injury):

Broken bones: ________________________ Fall (severe): _________________ Head trauma: _______

Sprain/strain: _________________________ Other: ____

Past Surgeries (type / year):

Back: _________________________________ Knee or hip replacement: ______________________

Other: ____ Pacemaker **Y / N**

Medications (check those that apply): ◻ Pain Killers ◻ Insulin ◻ Cholesterol Meds

◻ Blood Pressure Meds ◻ Muscle Relaxers ◻ Birth Control ◻ Other _________________

Supplements: ____

Please bring a complete current list of medications and supplements to your first appointment.

Lifestyle Habits:

Check the frequency that you drink the following beverages:

Alcohol	□ daily	□ weekly	□ occasional
Coffee	□ daily	□ weekly	□ occasional
Soda	□ daily	□ weekly	□ occasional
Tobacco use	□ never	□ former	□ current ______________packs per day

CASE HISTORY

The primary complaint or symptoms that have promoted me to seek care today include:

____

____

When did you first notice your current symptoms?____

Did symptoms begin gradually or after a certain event/activity? ______________________________________

How extreme are your symptoms on a scale of (0-10): With Activity: _______ At Rest: __________

How often do you feel the pain? Constant Frequently Comes and Goes

Symptoms are described as (**check all that apply**):

□ sharp	□ dull	□ burning
□ aching	□ throbbing	□ numbness
□ tingling	□ pins & needles	□ stiffness
□ shooting	□ aching	□ cramping
□ stabbing	□ nagging	□ radiating

Symptoms are worse in the (**check all that apply**): □ morning □ afternoon □ night

Check the things that make your symptoms worse:

□ bending	□ lying	□ walking
□ standing	□ sitting	□ movement
□ twisting	□ lifting	□ sleeping

Has your condition interfered with: □ work □ sleep □ daily routine

What have you tried to relieve the pain now, or in the past? ____

____

Have you been treated for this before? **Y / N** Results of previous treatment? ______________________________

Circle the area(s) of complaint