

Patient Information

Date _____

SS # _____

Patient Name _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Cell Phone (____) _____

Home Phone (____) _____

Best Place and time to reach you _____

In Case of Emergency, contact

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

Sex M F Age _____

Birth date _____

Married Widowed Single

Minor Separated Divorced

Partnered for _____ years

Patient _____

Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birth date _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Is this condition due to an accident?

Yes No Date _____

Type of Accident Auto Work

Home Other

To whom you made a report of your accident? Auto Insurance

Employer Worker Comp Other

Attorney Name (if applicable) _____

Patient Condition

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: Sharp Dull

Throbbing Numbness Aching

Shooting Burning Tingling

Cramps Stiffness Swelling

Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work

Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing

Walking Bending Lying Down

What treatment have you already received for your condition? Medication Surgery Physical Therapy Chiropractic Services None Other

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-ray _____
 Blood Test _____ Spinal Exam _____
 Chest X-ray _____ Urine Test _____
 Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|---------------------|--|------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsilitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Exercise:

None Moderate Daily Heavy

Work Activity:

Sitting Standing Light Labor Heavy Labor

Habits:

Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/day _____
 High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/ Surgeries you have had:

Description	Date
Falls _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Dislocations _____	_____
Surgeries _____	_____

Medications

Allergies

Vitamins/Herbs/Minerals

_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name _____

Pharmacy Phone (____) _____