

Patient Information

Patient _____ Sex **M** **F** Marital Status **S** **M** **Other**

SSN _____ Age _____ DOB ___/___/___

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Ext _____ Cell _____

Pager _____ Email _____

Employer _____ Occupation _____

Who may we thank for referring you? _____

Spouse _____ Employer _____ Work Phone _____

Children/Age _____

Emergency Contact _____ Relationship _____ Phone _____

Signature of Patient or Legal Guardian _____ Date _____

Account Information

Person responsible for the account _____ Cash _____ Insurance _____

Primary Insurance Company _____ Group # _____

Name of Insured _____ ID # _____

Insured's DOB ___/___/___ Sex **M** **F** Phone _____ Employer _____

Insured's Address _____
City _____ State _____ Zip _____

Secondary Insurance Company _____

Name of Insured _____ ID # _____

Insured's DOB ___/___/___ Sex **M** **F** Phone _____ Employer _____

Insured's Address _____
City _____ State _____ Zip _____

Is this condition due to an accident? _____ Auto _____ Work _____ Home _____ Other _____

Date of Accident _____ Police Report # _____ Claim # _____

Accident Reported to: Auto Insurance _____ Employer _____ Worker's Compensation _____ Attorney _____

Name of Attorney _____ Phone _____

Personal Health History

Medical Doctor _____ Location _____ Phone _____
 Last Chiropractor _____ Location _____ Phone _____

Daily habits: mSmoke? packs/day____, mCoffee/caffeine? cups/day____
 mAlcohol? drinks/week____, mExercise? type_____ hours/week _____

History of : mSurgery? If yes when and what for? _____
 mHospitalization? If yes when and why? _____
 mBroken bones? If yes when and which one (s)? _____

Women choose any that apply: m No menstrual cycle m Irregular menses m Heavy menses
 m Yeast infections m Intense cramping m Birth control pills
 m Pregnant Due date _____ Date of last menses _____

Reason for this office visit _____ When did this condition begin _____

How did this condition began _____

Is the condition getting: m better m worse m stays the same When do you notice it more _____

Describe the pain: m radiates m stays in one location m constant m comes and goes

What makes it feel better _____ worse _____

Does this condition interfere with your: m work m sleep m exercise m daily routine

Have you been treated by another healthcare provider for this condition? _____

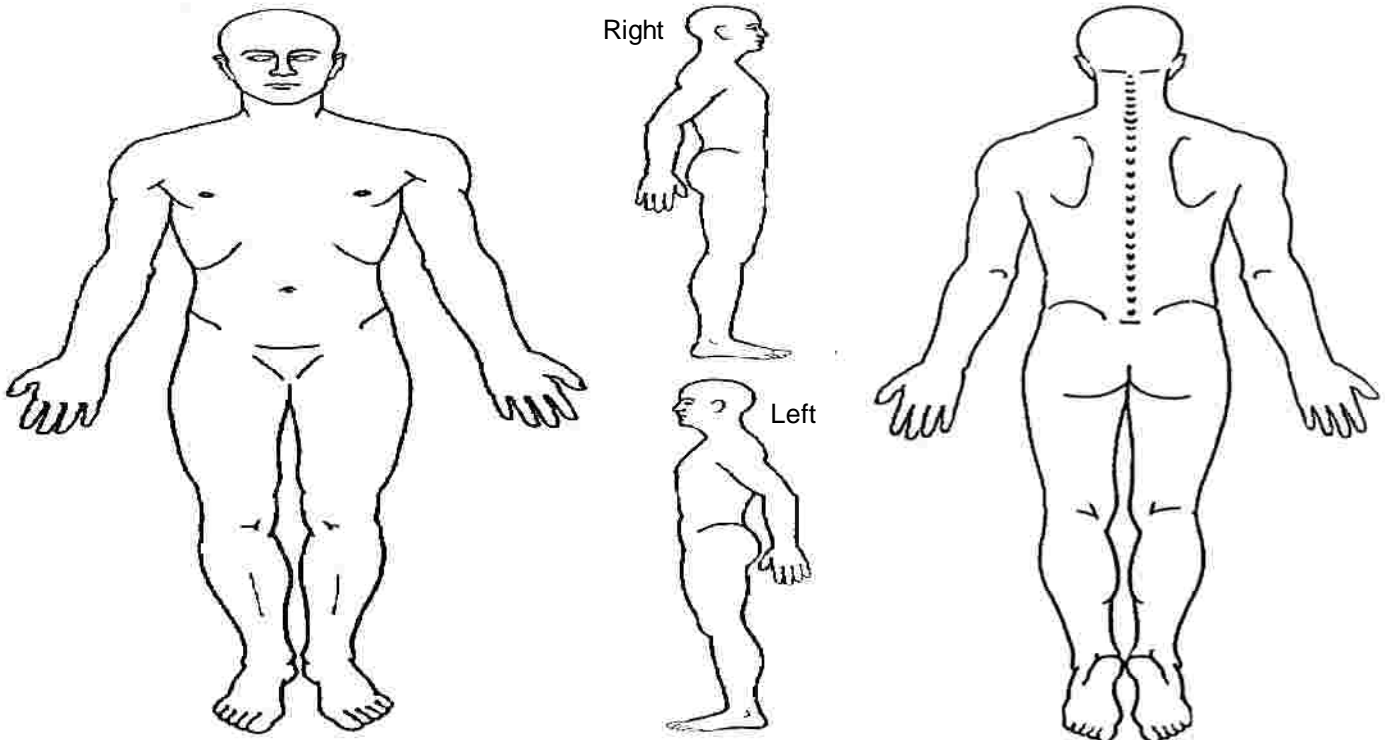
If so, who? _____ The results were: m disappointing m good m excellent

List your top three areas of pain and circle the level of intensity (1=mild-10=severe)

1. _____ 2. _____ 3. _____
 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using A B N S T

A = Achy B = Burning N = Numbing S = Stabbing T = Tingling



Personal Health History

~~PUT~~ **MARK** the condition(s) that bother you **now**.
CIRCLE the condition(s) that bothered you in the **past**.

HEAD	HOW LONG		HOW LONG
m Headache		m Numbness in finger (s):	
m entire head	_____	right hand left hand both hands	_____
m back of head	_____	m Loss of grip strength in:	
m forehead	_____	right hand left hand both hands	_____
m temples	_____	m carpal tunnel syndrome in:	
m Head feels heavy	_____	right left both hands	_____
m Loss of memory	_____	MID-BACK	
m Light-headedness	_____	m Pain between shoulder blades	_____
m Fainting	_____	m Muscle spasms	_____
m Pain in eyes	_____	CHEST	
m Light bothers eyes	_____	m Chest pain	_____
m Loss of smell	_____	m Pain around ribs:	
m Loss of taste	_____	right left both	_____
m Loss of balance	_____	LOW BACK	
m Pain in Ears	_____	m Low back pain	_____
NECK		Low back pain is worse when:	
m Pain in the neck	_____	m sitting	_____
m Stiff neck	_____	m standing	_____
m Muscle spasms in neck	_____	m bending	_____
m Grinding sounds in neck	_____	m lifting	_____
m Popping sounds in neck	_____	m coughing	_____
m Arthritis in neck	_____	m Muscle spasms	_____
SHOULDERS		HIPS, LEGS & FEET	
m Pain in:		m Pain in buttocks:	
right left both	_____	right left both	_____
m Bursitis in:		m Pain in hip joint (s):	
right left both	_____	right left both	_____
m Muscles spasm in shoulders	_____	m Pain down leg (s):	
ARMS/HANDS		right left both	_____
m Pain in arm (s):		m Cramps in leg (s):	
right left both	_____	right left both	_____
m Numbness in arm (s):		m Numbness in leg (s):	
right left both	_____	right left both	_____
m Pain in forearm (s):		m Pain in knee (s):	
right left both	_____	right left both	_____
m Numbness in forearm (s):		m Swollen ankle (s):	
right left both	_____	right left both	_____
m Pain in wrist (s):		m Pain in foot (feet):	
right left both	_____	right left both	_____
m Pain in hand (s):		m Numbness in foot (feet):	
right left both	_____	right left both	_____
m Numbness in hand (s):		m Always cold foot (feet):	
right left both	_____	right left both	_____
m Cold hand (s):		m Cramps in the foot (feet):	
right left both	_____	right left both	_____
m Arthritis in hand (s):		m Pain in toe (s):	
right left both	_____	right left both feet	_____
m Pain in finger (s):		m Numbness in toe (s):	
right left both hands	_____	right left both feet	_____

