Confidential Information

Personal Information

Name ____Age _________Today's Date ___________
Address _____________________________________ City ________________ State_____ Zip________
Phone (preferred) ________________________ Date of Birth ___________________
Gender:_______________ Marital Status: S M D W Weight:_________lbs.
Occupation ____Employer______________________________

Emergency Contact:
Name_____________________________Phone____________Relationship to Patient_________________

How did you hear about us? ____

Health History

Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: ____
Are you currently taking prescribed medication? __ Yes __ No
List prescribed medications you are currently taking:

____

____

List conditions you are currently taking medications for:

____

List over the counter medications currently taking:

____

History of any surgeries?:

____

____

____

History of breaks/ fractures/ dislocations/ or replacements?

____

____

____

Have you now or anytime previously been diagnosed with high blood pressure, diabetes, osteoporosis, blood disorders, or any cancers?

____

____

____

Have you been diagnosed with any other chronic conditions presently or in the past?

____

____

Do you smoke Y/N How much/ often ____________________Alcohol Use: __Daily __Weekly __Socially

Caffeinated drinks per day ____ Do you take Vitamins/Supplements Y/N
List supplements below:

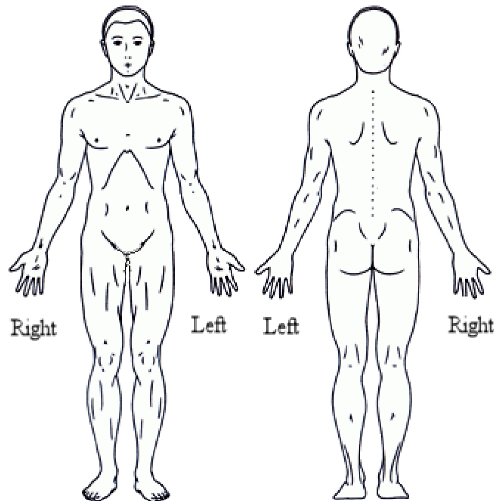
____

____

____

Reason for seeking chiropractic care:
____
____
List any other doctors seen for this:
____
List any diagnosis & treatment tried for this:
____
____
Have you had this issue before? __ Yes __ No
If yes, explain: ____
Family history of this issue?____
Have you received chiropractic treatment in the past? __ Yes __ No
Name of previous chiropractor and reason for past care:
____
____

Musculoskeletal:



On the image to the left, please circle areas of concern.

Please circle degree of pain, 0=none, 10= severe pain.
0 1 2 3 4 5 6 7 8 9 10
How would you describe the pain?
- Numbness
- Dull Ache
- Burning
- Sharp/Stabbing
- Pins, Needles
- Other ______

What activities aggravate your condition/pain?_______________________________
____
What activities lessen your condition/pain?_______________________________

Does the pain stay in one spot or does it radiate?
____
Is this condition worse during certain times of the day? Y/N ____________________________
Is this condition interfering with any of the following:
Work?__________ Sleep?__________Routine?_______Other?_______________________
Please describe how this condition interferes with any of the above:
____
____
Is this condition progressively getting worse? ____________________________________

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature____Date___________