Name ____ Date ______________

Address ______________________ City ______________ State ______ ZIP ________

Phone (H) ________________ Soc Sec Number ____________ Date of Birth __________ Age ___

Phone (Cell) __________________ E-mail address ______________________________

Marital Status S M D W Number of Children ________ Have you been here before? Y N When? ________

Occupation ________________ Employer ____________________ Years there ____________

Employer's Address ______________ City ____________ State ______ Phone (W) ____________

Spouse's Name __________________ Date of Birth ____________ Spouse is the policy holder? Y N

Occupation ______________________ Employer ______________________________

How did you hear about this office? ____

Are you covered by Medicare? Y N Are you covered by State Insurance Aid? Y N

Do you have group, union or other personal health insurance? Y N

What is your major complaint? ____

How did you do this? ____

How long have you had this? __________ Have you had this before? Y N When? ________________

Have you missed work? Y N How long were you out of work? ____________________________

Is this condition getting worse? Y N Is this problem constant or does it come and go? ____________

How long since you really felt good? ______________

What activities aggravate your condition? [ ] Working [ ] Lifting [ ] Stooping [ ] Standing [ ] Sitting [ ] Bending

[ ] Laying Down [ ] Walking [ ] Daily Routine [ ] Other: ______________________________

My pain is better when I: [ ] Rest [ ] Use Ice [ ] Use Heat [ ] Stretch [ ] Move Around [ ] Work [ ] Stand [ ] Sit

[ ]Chiropractic Adjustment [ ] Lay Down [ ] Massage [ ] Walk [ ] Take Time off From Work

[ ] Use Ointment, What? ______________ [ ] Take drugs, What? ______________________

List date and type of surgeries or hospitalizations ______________________________________

Smoking Status: [ ] Never smoke [ ] Former Smoker [ ] Current – sometimes smoker [ ] Current – every day smoker

Do you have any medication allergies: Y N What? ______________________________

Are you currently take any medications? Y N What, mg? __________________________

What non-prescription drugs, vitamins or supplements are you taking? ________________________

Other doctors seen for this condition ____

Have you had any X-ray, MRI or CT scans? Y N For What? ____________________________

Family doctor __________________ Date of last visit ____________ For what? ____________

Have you ever seen a Chiropractor? Y N Who? ______________ For what? ________________

Date of last visit to a Chiropractor ____________ Date of last x-rays by a Chiropractor ______________

Do you have a pacemaker? Y N Do you have now or have ever had any type of cancer? Y N

Do you have now or have ever had any type of infection? Y N

Other complaints: ____

All of the above information is true and correct. I clearly understand and agree that all services rendered to 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 and treatment for any reason, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature ______________________________ **Date** ______________

***PLEASE TURN OVER AND COMPLETE OTHER SIDE

NECK

Pain in neck	Y N	Pinched nerve in neck	Y N
Neck pain with movement	Y N	Neck feels out of place	Y N
Bending head forward	Y N	Muscle spasm in neck	Y N
Bending head backward	Y N	Grinding sounds in neck	Y N
Turning head	L R	Popping sounds in neck	Y N
Bending head	L R		

SHOULDERS

Pain in shoulder joints	L R	Can't raise arm above head	L R
Pain across shoulders	Y N	Tension in shoulders	Y N
Bursitis in shoulders	L R	Pinched nerve in shoulders	L R
Arthritis in shoulders	L R	Muscle spasm in shoulders	L R
Can't raise arm above shoulders	L R		

ARMS & HANDS

Pain in upper arm	L R	Pain in forearm	L R
Pain in elbow	L R	Pain in hands	L R
Moving aggravates the pain	L R	Pain in fingers	L R
Tennis elbow	L R	Pins & needles in arm	L R
Arms are numb/go to sleep	L R	Pins & needles in fingers	L R
Fingers are numb/go to sleep	L R	Hands cold	L R
Arthritis/swelling in hands	L R	Loss of grip strength	L R

LOW BACK

Upper low back pain	Y N	Sacroiliac (SI) or hip pain	L R
Lower low back pain	Y N	Slipped, bulging/herniated disk	Y N
Low back feels out of place	Y N	Muscle spasm in lower back	Y N

HIPS, LEGS & FEET

Pain in buttocks	L R	Pain in hip joint	L R
Pain down leg	L R	Knee pain	L R
Leg cramps	L R	Foot cramps	L R
Pins & needles feeling	L R	Cold feet	L R
Numbness in leg	L R	Numbness in toes	L R
Swollen feet	L R	Swollen ankle	L R

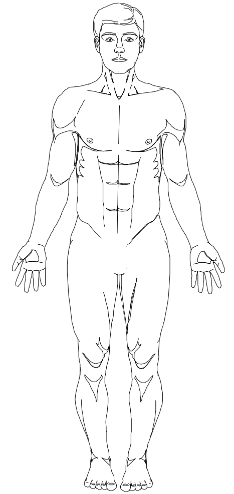
WOMEN ONLY

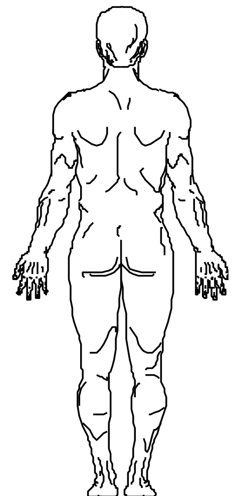
Menstrual pain	Y N	Cramping	Y N
Irregularity	Y N	Are you pregnant	Y N

MEN ONLY

Trouble starting urination	Y N	Excessive night urination	Y N
Prostate pain or swelling	Y N	Frequent urination	Y N

Please use the pictures below and mark your problem with an X.





Other remarks below:

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