

Date: _____

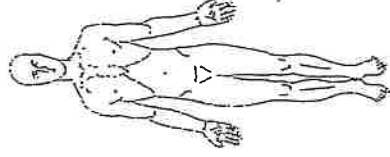
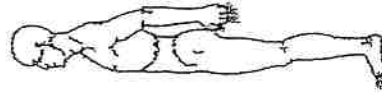
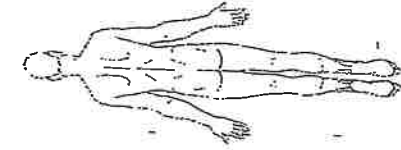
Patient Name: _____

Account #: _____

PATIENT HISTORY

Using the letters below, please show where you are experiencing all of your complaints on the diagram:

- A. Ache
- B. Burning
- C. Cramping
- D. Dull Pain
- F. Stiffness
- N. Numbness
- R. Throbbing
- S. Soreness
- T. Tingling
- X. Sharp Pain
- Z. Shooting Pain



	1 st Complaint	2 nd Complaint	3 rd Complaint	4 th Complaint	5 th Complaint
Complaint:					
When did it start?					
On a scale of 1 - 10					
1 -- mild					
5 -- moderate					
10 -- severe					
Rate your pain levels:					
What % of the time does it occur?	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100
When does it occur most?	__AM__PM Night	__AM__PM Night	__AM__PM Night	__AM__PM Night	__AM__PM Night
How long does it last?	__Minutes__Hours Days Constant	__Minutes__Hours Days Constant	__Minutes__Hours Days Constant	__Minutes__Hours Days Constant	__Minutes__Hours Days Constant
What makes it better?					
What makes it worse?					
Current:					
Average:					
At Best:					
At Worst:					
Driving	Y N	Y N	Y N	Y N	Y N
Exercising	Y N	Y N	Y N	Y N	Y N
Housework	Y N	Y N	Y N	Y N	Y N

Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

Walking Y N Kneeling Y N Grooming Y N Driving Y N

Bending Y N Sitting Y N Standing Y N Exercising Y N

Sleeping Y N Lifting Y N Running Y N Housework Y N

- Have you ever had the condition(s) in the past? Yes No
If yes, please indicate if any treatment was received and what type of treatment:
 Hospitalization Chiropractic care Medical doctor / specialty provider None
- Have you ever lost time from work due to your condition(s)? Yes No
If Yes, dates? _____
- Are you pregnant? Yes No
- What was the first day of your last menstrual cycle? _____
- Number of pregnancies? _____ Number of miscarriages? _____

Patient Signature: _____

Doctors Signature: _____

Date: _____

WELCOME

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name Last Name _____ Middle Initial _____
Address _____
City _____ Zip _____
State _____
E-mail _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone (____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____
Cell Phone (____) _____
Best time and place to reach you,
IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Home Phone (____) _____
Work Phone (____) _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

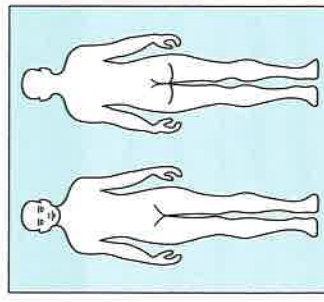
Signature of Patient, Parent, Guardian or Personal Representative _____
Please print name of Patient, Parent, Guardian or Personal Representative _____
Date _____ Relationship to Patient _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No
Date _____
Type of accident Auto Work Home Other
To whom have 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? Yes No Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
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



HEALTH HISTORY

What treatment have you already received for your condition? Medications 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 _____

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

EXERCISE

None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____
 Drinks/Week _____

Cups/Day _____
 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 (____) _____

