

# WELCOME

## PATIENT INFORMATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F Marital Status: S M D W  
Social Security # \_\_\_\_\_  
Occupation Employer \_\_\_\_\_ Phone (Work) \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Spouse's Phone (Work) \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

## ACCIDENT INFORMATION

Present condition due to an injury?  Yes  No  On the Job  Auto Accident  Other \_\_\_\_\_  
Has the accident been reported?  Yes  No  To Employer  Auto Carrier  Other \_\_\_\_\_  
Attorney name (if applicable) \_\_\_\_\_

## HEALTH REPORT:

Reason for seeking care: \_\_\_\_\_  
List any other doctors seen for this: \_\_\_\_\_  
List any diagnosis and type of treatment: \_\_\_\_\_  
Have you had similar accidents or injuries before?  Yes  No If yes, explain: \_\_\_\_\_  
Have you received chiropractic treatment previously?  Yes  No  
If yes, explain: \_\_\_\_\_  
Have you been treated for any health condition by a physician in the last year?  Yes  No  
If yes, explain: \_\_\_\_\_  
Are you currently taking medication?  Yes  No list medications: \_\_\_\_\_  
\_\_\_\_\_  
Have you taken medication in the past?  Yes  No list medications \_\_\_\_\_  
List conditions you are taking medications for: \_\_\_\_\_  
List the approximate dates of any surgery or treated conditions: \_\_\_\_\_  
\_\_\_\_\_

Family History: Health conditions, age of death and cause of death.

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother/s & Sister/s: \_\_\_\_\_

Do you smoke Y/N \_\_\_\_\_ •Alcohol Y/N  Daily  Weekly  Social Occasions •Caffeinated drinks per day \_\_\_\_\_

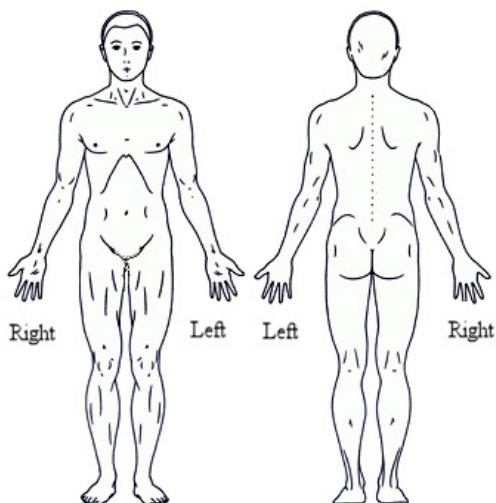
Do you take Vitamins/Supplements Y/N If yes, type and how often \_\_\_\_\_

Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	===
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins, Needles	+++
Other _____	^^^



What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition progressively getting worse? \_\_\_\_\_

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**Please mark each item below for each sign or symptom you presently have or previously had:**

**GENERAL SYMPTOMS**

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

**MUSCLES & JOINTS**

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

**CARDIO-VASCULAR**

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

**EAR/NOSE/THROAT**

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

**GASTRO-INTESTINAL**

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

**RESPIRATORY**

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

**GENITO-URINARY**

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

**SKIN OR ALLERGIES**

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy \_\_\_\_\_

**FOR WOMEN ONLY**

- Birth Control \_\_\_\_\_
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time Y/N

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 \_\_\_\_\_