Demographic Information

* Denotes required information

Patient Name

Title: ______________________________
Nick Name: ______________________________
*First Name: ______________________________
Middle Name: ______________________________
*Last Name: ______________________________
Suffix: ______________________________

Address

Address 1: ______________________________
Address 2: ______________________________
City: ______________________________
State: ______________________________
*Zip: ______________________________

Contact Information

Primary phone: ______________________________
Secondary phone: ______________________________
Mobile phone: ______________________________
Work email: ______________________________
Home email: ______________________________
Best Contact Method: ______________________________

Personal Information

*Date of Birth: ______________________________
Social Security Number: ______________________________
*Gender: ______________________________
Marital Status __ Single __ Married __ Other
Employment Status: __ Employed __ FT Student __ PT Student __ Retired __ Other __ Self Employed
Race: __ White __ Black/African American __ Hispanic __ American Indian/Alaska Native
__ Asian Indian __ Chinese __ Filipino __ Japanese __ Korean __ Vietnamese
__ Native Hawaiian/Pacific Islander __ Guamanian or Chamorro __ Samoan __ Other
Multi-Racial: __ Yes __ No
Ethnicity: __ Hispanic or Latino __ Non-Hispanic or Latino
Preferred language: ______________________________

Verification Question:
__ In what city were you born?
__ What high school did you attend?
__ What is your favorite color?
__ What is your favorite movie?
__ What is the name of your favorite pet?
__ What street did you grow up on?
__ What was the make of your first car?
__ When is your anniversary?

Verification Answer: ______________________________
Name of primary care physician: ______________________________
Have you ever consulted a chiropractor before? __ Yes __ No
If so, who: ______________________________
Last visit: ______________________________
Referred by: ______________________________

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Employment Information

* Denotes required information

*Occupation: ______________________________
Employer Name: ______________________________
Employer Address: ______________________________
Employer City: ______________________________
Employer State: ______________________________
Employer Zip: ______________________________
Work Phone: ______________________________
May we call your cell phone at work: __ Yes __ No
May we call your work phone: __ Yes __ No

Other Health Care Providers

* Denotes required information

*Provider Name: ______________________________
Provider Type: ______________________________
Provider City: ______________________________
Provider State: ______________________________
Provider Phone: ______________________________
*I have seen this provider for my primary problems: __ Yes __ No

*Provider Name: ______________________________
Provider Type: ______________________________
Provider City: ______________________________
Provider State: ______________________________
Provider Phone: ______________________________
*I have seen this provider for my primary problems: __ Yes __ No

*Provider Name: ______________________________
Provider Type: ______________________________
Provider City: ______________________________
Provider State: ______________________________
Provider Phone: ______________________________
*I have seen this provider for my primary problems: __ Yes __ No

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Problem Areas

* Denotes required information

*Describe your problem: ____________________

____

*On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

*How did your problem begin: ____________________

____

*Onset date of problem: ____________________

How often do you experience symptoms: ____________________

What is the nature of your symptoms: __ Dull __ Sharp __ Throbbing __ Burning __ Deep
__ Aching __ Tingling __ Stabbing __ Cramping
__ Numbness __ Radiating

Does it affect other areas of your body: __ Yes __ No

To what areas does the pain radiate, shoot or travel: ____________________

What makes it better or worse? (Times of day, movements, activities):

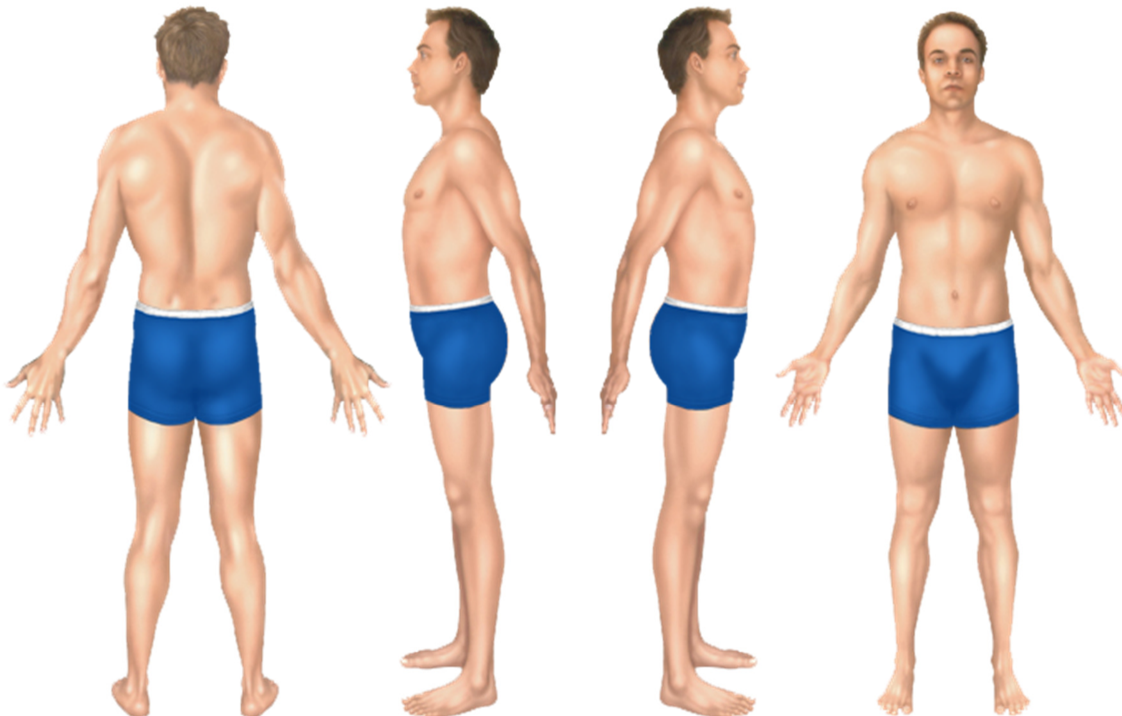
____

What have you done to relieve the symptoms: __ Prescription Medication __ Over the counter drugs
__ Homeopathic remedies __ Physical Therapy
__ Surgery __ Acupuncture __ Chiropractic
__ Massage __ Ice __ Heat __ Other

*What should we know about your current condition: ____________________

____

Location of symptoms



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Medications

* Denotes required information

*Name: ____________________
Dosage: ____________________
*Start Date: ____________________
*Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

*Name: ____________________
Dosage: ____________________
*Start Date: ____________________
*Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

*Name: ____________________
Dosage: ____________________
*Start Date: ____________________
*Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

Nutritional Supplements

* Denotes required information

*Name: ____________________
*Start Date: ____________________
Manufacturer: ____________________
Quantity: ____________________
Frequency: ____________________
Taken with water: __ Yes __ No
Reason for taking: ____________________
Comments: ____________________

*Name: ____________________
*Start Date: ____________________
Manufacturer: ____________________
Quantity: ____________________
Frequency: ____________________
Taken with water: __ Yes __ No
Reason for taking: ____________________
Comments: ____________________

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Allergies

* Denotes required information

*Name: ______
Medication related: __ Yes __ No
Symptom: ______
*Start Date: ______
Comments: ______

*Name: ______
Medication related: __ Yes __ No
Symptom: ______
*Start Date: ______
Comments: ______

Personal Medical History

Illnesses

Illness: ______
Start date: ______
End date: ______

Illness: ______
Start date: ______
End date: ______

Surgeries

Surgery: ______
Date: ______

Surgery: ______
Date: ______

Hospitalizations

Reason: ______
Date: ______
Duration: ______

Reason: ______
Date: ______
Duration: ______

Injuries

Injury: ______
Date: ______

Injury: ______
Date: ______

Family Medical History

Illnesses

Illness: ______
Relation: ______
Age of onset: ______

Illness: ______
Relation: ______
Age of onset: ______

Illness: ______
Relation: ______
Age of onset: ______

Illness: ______
Relation: ______
Age of onset: ______

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Review of Body Systems

Musculoskeletal
__ No issues

Condition				Condition			
Osteoporosis:	__ Have	__ Had	__ No	Arthritis:	__ Have	__ Had	__ No
Scoliosis:	__ Have	__ Had	__ No	Neck Pain:	__ Have	__ Had	__ No
Back Problems	__ Have	__ Had	__ No	Hip Disorders	__ Have	__ Had	__ No
Knee injuries:	__ Have	__ Had	__ No	Foot/ankle pain:	__ Have	__ Had	__ No
Shoulder Problem:	__ Have	__ Had	__ No	Elbow/Wrist Pain:	__ Have	__ Had	__ No
TMJ Issues:	__ Have	__ Had	__ No	Poor Posture:	__ Have	__ Had	__ No

Neurological
__ No issues

Condition				Condition			
Anxiety:	__ Have	__ Had	__ No	Depression:	__ Have	__ Had	__ No
Headaches:	__ Have	__ Had	__ No	Dizziness:	__ Have	__ Had	__ No
Pins & needles:	__ Have	__ Had	__ No	Numbness:	__ Have	__ Had	__ No

Cardiovascular
__ No issues

Condition				Condition			
High Blood Pressure:	__ Have	__ Had	__ No	Low Blood Pressure:	__ Have	__ Had	__ No
High cholesterol:	__ Have	__ Had	__ No	Poor circulation:	__ Have	__ Had	__ No
Angina:	__ Have	__ Had	__ No	Excessive bruising:	__ Have	__ Had	__ No

Respiratory
__ No issues

Condition				Condition			
Asthma:	__ Have	__ Had	__ No	Apnea:	__ Have	__ Had	__ No
Emphysema:	__ Have	__ Had	__ No	Hay fever:	__ Have	__ Had	__ No
Shortness of breath:	__ Have	__ Had	__ No	Pneumonia:	__ Have	__ Had	__ No

Digestive
__ No issues

Condition				Condition			
Anorexia/bulimia:	__ Have	__ Had	__ No	Ulcer:	__ Have	__ Had	__ No
Food sensitivities:	__ Have	__ Had	__ No	Heartburn:	__ Have	__ Had	__ No
Constipation:	__ Have	__ Had	__ No	Diarrhea:	__ Have	__ Had	__ No

Sensory
__ No issues

Condition				Condition			
Blurred vision:	__ Have	__ Had	__ No	Ringing in ears:	__ Have	__ Had	__ No
Hearing loss:	__ Have	__ Had	__ No	Chronic ear infection:	__ Have	__ Had	__ No
Loss of smell:	__ Have	__ Had	__ No	Loss of taste:	__ Have	__ Had	__ No

Integumentary
__ No issues

Condition				Condition			
Skin cancer:	__ Have	__ Had	__ No	Psoriasis:	__ Have	__ Had	__ No
Eczema:	__ Have	__ Had	__ No	Acne:	__ Have	__ Had	__ No
Hair loss:	__ Have	__ Had	__ No	Rash:	__ Have	__ Had	__ No
					__ Have	__ Had	__ No

Endocrine
__ No issues

Condition				Condition			
Thyroid issues:	__ Have	__ Had	__ No	Immune disorders:	__ Have	__ Had	__ No
Hypoglycemia:	__ Have	__ Had	__ No	Frequent infection:	__ Have	__ Had	__ No
Swollen glands:	__ Have	__ Had	__ No	Low enegery:	__ Have	__ Had	__ No

Genitourinary
__ No issues

Condition				Condition			
Kidney stones:	__ Have	__ Had	__ No	Infertility:	__ Have	__ Had	__ No
Bedwetting:	__ Have	__ Had	__ No	Prostate issues:	__ Have	__ Had	__ No
Erectile dysfunction:	__ Have	__ Had	__ No	PMS symptoms:	__ Have	__ Had	__ No

Constitutional
__ No issues

Condition				Condition			
Fainting:	__ Have	__ Had	__ No	Low libido:	__ Have	__ Had	__ No
Poor appetite:	__ Have	__ Had	__ No	Fatigue:	__ Have	__ Had	__ No
Sudden weight gain/loss:	__ Have	__ Had	__ No	Weakness:	__ Have	__ Had	__ No

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Smoking History

* Denotes required information

*Do you currently smoke: __ Yes __ No
Years smoked: ______________________
Packs a day: ______________________
Interest in quitting on a scale of 0-10: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
How long since you stopped: ______________________

Social History

* Denotes required information

Consumption

How much alcohol do you drink daily: ______________________
How many cups of coffee do you drink daily: ______________________
How much soda pop do you drink daily: ______________________
How much water do you drink daily: ______________________
How much do you depend on pain relievers: ______________________
Do you use recreational drugs: __ Yes __ No

Stress Information

*How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot
*How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot
What are the major stressors in your life: ______________________

Sleeping Information

How many hours do you sleep per night: ______________________
What is your preferred sleeping position: ______________________
What type of mattress & pillow do you have: ______________________
How old are your mattress & pillow: ______________________

Healthy Eating & Exercise Information

How much regular exercise do you perform: ______________________
*Rate your healthy eating habits: Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy
Typical eating habits: __ Skip Breakfast __ 2 meals per day __ 3 meals per day
__ Snacking between meals

What would be the most significant thing that would improve your health:

____

____

What additional health goals do you have:

____

____

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Daily Activities
* Denotes required information

Rate the difficulty of the following daily activities on a scale of 0-10 (0 being easiest, 10 most difficult):

Activity	*__Current Difficulty__	*__Prior Difficulty__
Bending:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Carrying:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Driving:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Housework:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Lying:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Opening jars:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Personal care:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Picking up objects:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Pulling:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Pushing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reaching:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reaching behind:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reading:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Recreation:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Running:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Shopping:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sit to stand:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sitting:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sleeping:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Standing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Throwing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Walking:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Writing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Comments: ____

____

____

____

____

____

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Acknowledgements

Chiropractic care:	☐	I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
Privacy Verification:	☐	I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Permission to contact:	☐	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Payment Verification:	☐	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
X-ray Verification: *(females only)*	☐	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period:
General Verification:	☐	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: ______________________________ Date: ______________________

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