

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/____ Age: _____ Male Female
 Address: _____ City, State, Zip Code: _____
 Marital Status: Single Married Widowed Divorced # of Children: _____
 Spouse's (or parent's) Name: _____ Social Security #: _____
 Home Phone # (____) _____ Cell Phone # :(____) _____ Email: _____
 Emergency Contact: _____ Phone#:(____) _____
 Employer/Occupation: _____ Work#:(____) _____
 How were you referred to this office? _____

Please list your chief complaints in order of severity:

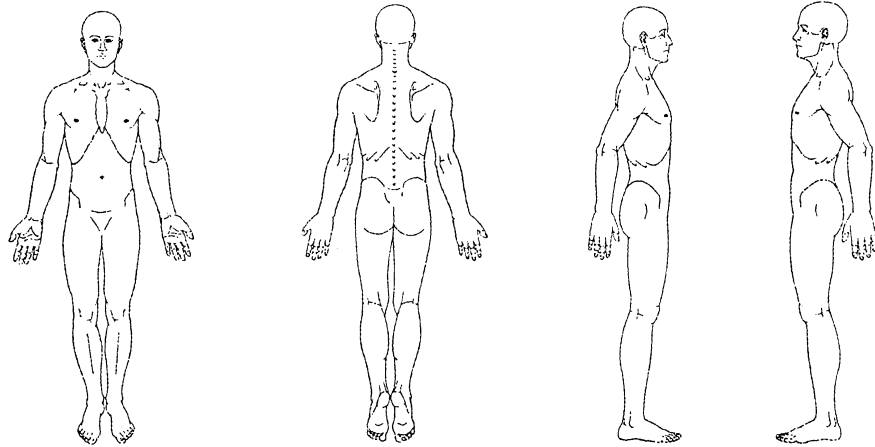
1. _____ When did it begin? _____
2. _____ When did it begin? _____
3. _____ When did it begin? _____

Are any of these complaints work related? Yes No Due to a recent auto accident? Yes No

Please use the diagrams below to indicate the location and type of pain you are experiencing at this time.

Key

A: Ache
 B: Burning
 D: Dull Pain
 M: Muscle Spasm
 N: Numbness
 P: Pins and Needles
 S: Sharp Pain
 T: Tingling



Have you ever had chiropractic care before? Yes No If yes, when and by whom? _____
 Who is your primary care physician or group/clinic? _____
 May we contact your physician if necessary? Yes No Doctor's phone #: _____
 When was your last complete physical exam? _____
 Please list any doctors consulted for the above conditions: _____

Have you had any prior serious accidents or injuries (i.e., car accidents, bad falls, broken bones)? Yes No
 If yes, please list by date: _____

Please list any major surgeries or hospitalizations by date: _____

Please list all medications you are currently taking and what they are for: _____

I certify that the above information is true and correct to the best of my knowledge.

Print Patient's Name: _____

Signature: _____
 (Patient, Parent or Legal Guardian)

Date: ____/____/____

Name: _____

Date: ____/____/____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. These questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care. The Doctor may ask you for more details regarding the boxes you have marked.

Please check any of the following diseases you have ever had:

Measles	Polio	Thyroid Problems
Mumps	Rheumatic Fever	Arthritis
Chicken Pox	Anemia	Epilepsy
Whooping Cough	Heart Disease	Sexually Transmitted Disease
Pneumonia	Cancer	Substance Abuse
Tuberculosis	Diabetes	Mental Disorder
Other Diseases Not Listed:		

Please check any of the following conditions that you currently have or have had in the past 6 months:

Low Back Pain	Allergies	Irregular Heartbeat
Pain Between Shoulders	Difficulty Sleeping	Heart Problems
Neck Pain	Fever	Lung Problems
Arm Pain	Headaches	Congestion
Joint Pain/Stiffness	Loss of Appetite	Varicose Veins
Difficulty Walking	Excessive Thirst	Ankle Swelling
Difficulty Chewing	Frequent Nausea	Men Only
Clicking Jaw	Vomiting	Sexual Dysfunction
Numbness	Diarrhea/Constipation	Prostate Problems
Paralysis	Hemorrhoids	Date of Last Prostate Exam: / /
Dizziness	Liver Trouble	Women Only
Forgetfulness	Weight Gain	Menstrual Irregularity
Confusion	Weight Loss	Menstrual Pain
Depression	Abdominal Cramps	Vaginal Pain
Fainting	Gas/Bloating After Meals	Vaginal Infections
Convulsions	Heartburn	Breast Pain
Cold/Tingling in Hands	Black/Bloody Stools	Breast Lumps
Cold/Tingling in Feet	Bladder Infections	Date of Last PAP: / /
Vision Problems	Painful Urination	Date of Last Period: / /
Dental Problems	Excessive Urination	Could You Be Pregnant? Yes No
Sore Throat	Discolored Urine	Other Conditions Not Listed:
Earaches	Chest Pain	
Difficulty Hearing	Shortness of Breath	
Stuffed Nose	High Blood Pressure	

Doctor's Notes: