Name_____ **Nickname**_____

Address_____**City**_____ **State**_____ **Zip** _____

Cell Phone_____ **Home Phone** _____**Work Phone**_____

Home Email _____ **Work Email**_____

Emergency Contact: _____ **Contact Phone #** _____

Date of Birth_____ **Age**_____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____**Employer**_____ **Employer Phone** _____

Do you have insurance? ❑ Yes ❑ No **Insurance Name:** _____

Primary insured? ❑ Yes ❑ No **If no, primary insured name and relationship to self:** _____

Family Physician: _____ **Phone:** _____

Current medications, including Over the Counter: **No current Medications, check here:** ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

Allergies you have to medications, foods or environment: **No known Allergies, check here:** ❑

1) _____ **3)** _____

2) _____ **4)** _____

5) _____ **6)** _____

7) _____ **8)** _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

_____

FAMILY HISTORY: Please mark any condition that **YOU** or **YOUR FAMILY** have or have had in the past.

- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Mental Illness
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ High Cholesterol
- ☐ HIV or Other Immune Disease
- ☐ Other_____

Past Health History: Please mark any condition you have now or had in the past

General	Hematology	GU	Skin	GI	Neurological
□Fever	□Anemia	□Painful urination	□Rashes	□Nausea/Vomiting	□Numbness
□Fatigue	□Blood Thinners	□Incontinence	□Redness	□Liver disease	□Tingling
□Weight gain	□Recent Infection	□Blood in Urine	□Psoriasis	□Constipation	□Pinched nerve
□Weight loss	□HIV / AIDS	□Kidney disease	□Eczema	□Diarrhea	□Concussion
MSK	**Endocrine**	□Kidney stones	**Head**	□Indigestion	□Memory loss
□Arthritis	□Temp intolerance		□Trauma	□Bloating	□Dizziness
□Joint pain	□Frequent urination	**Nose**	□Headaches	□Abdominal Pain	□Tremors
□Neck pain	□Excessive thirst	□Runny nose	□TMJ	□Blood in Stool	□Recent falls
□Mid back pain	**Eyes**	□Congestion	**Psychiatric**	□Food Intolerance	**Cardiac**
□Low back pain	□Eye pain	□Sinus pain	□Anxiety	**Respiratory**	□Chest Pain
□Swelling	□Vision change	**Males Only**	□Depression	□Cough	□ Palpitations
□Weakness	**Ears**	□Low libido	□Suicidal thoughts	□Short of breath	□Swollen ankles
□Osteoporosis	□Ear Ringing	□Infertility	**Females Only**	□Wheezing	□Calf Pain
□Rheumatism	□Difficult Hearing	□Loss muscle mass	□Painful cycles	□Asthma	□Heart problems
□Fibromyalgia	□Discharge	□Erectile dysfunction	□Ovarian cysts	□COPD	□Aortic aneurysm

Who referred you to our office (Please be as detailed as possible)_____

_____

Have you ever had chiropractic care ❑ Yes ❑ No **If Yes, Dr. Name** _____ **Date of last visit** _____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

1. **On the scale below, please circle the Severity of your Main Complaints at their Worst.**

Mild				*Moderate*				*Severe*	
1	2	3	4	5	6	7	8	9	10

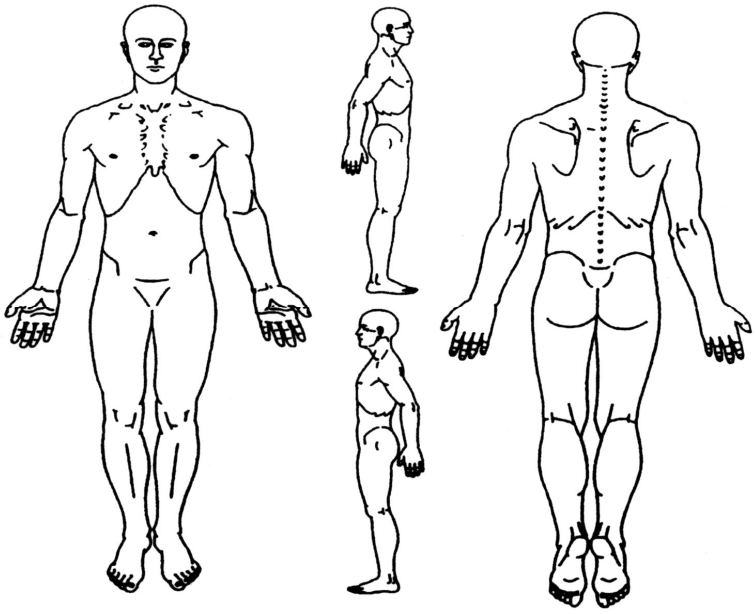
2. **On the scale below please circle the Percentage of Time you experience your Main Complaints:**

Occasional				*Intermittent*			*Frequent*			*Constant*
0	10	20	30	40	50	60	70	80	90	100

3. **Have these problems been getting ❑ worse or ❑staying the same?**
4. **Have you ever experienced any of these complaints while working?** _____ If yes, please describe what activities at work may be causing you these complaints:_____
5. **Are there any other activities, incidents, or events outside of work that may have caused these complaints?** _____ If yes, please explain: _____
6. **Have you at any time in the past ever suffered a work injury?** _____ If yes, what is the date of injury? _____
7. **Have you been involved in an auto accident in the last 12 months?** ❑ Yes ❑ No If yes, date of the accident _____

8. **On the diagram below, please show where you are experiencing All present complaints using the following letters:**

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T**: tingling **S:** sharp



The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely **able** to function — Totally **unable** to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members driving children to school, etc.) _____
2. RECREATION: hobbies, sports, and other similar leisure time activities. _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

Patient Signature _____ **Date** _____