ABOUT YOU

First Name _____ **Middle Name** _____

Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code** _____

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email _____

Date of Birth ____ / ____ / _____ **Gender** ☐ Male ☐ Female

Height _____'_____" **Weight** _____ lbs

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____ **Spouse's Name** _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-_____ **Relation To You** _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____ **Phone** ____-____-_____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code**_____

ID/Policy Number _____ **Group Number** _____

Insured's Name _____ **Insured's Date of Birth** ____ / ____ / _____

REFERRAL INFORMATION.

Referring Physician _____ **Contact information.** _____

Referring Patient _____

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us?

☐ Word of mouth ☐ Advertisement ☐ Social media ☐ Direct marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

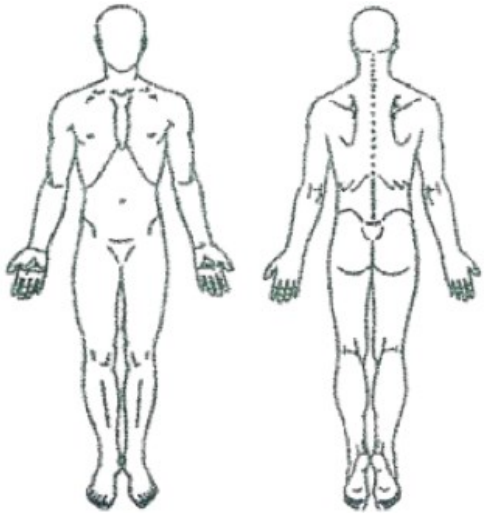
What caused this condition _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None										*Unbearable*
0	1	2	3	4	5	6	7	8	9	10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment, if any, have you received since the injury? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints	☐ No	☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No	☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose or Throat	☐ No	☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No	☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No	☐ Yes	**Explain:** _____
Stomach, Bowels or Digestive Conditions	☐ No	☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No	☐ Yes	**Explain:** _____
Diabetes, Thyroid or Glandular Conditions	☐ No	☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No	☐ Yes	**Explain:** _____
Do you have any medication allergies?	☐ No	☐ Yes	**Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes **Explain:** _____

Are you presently taking any medication? ☐ No ☐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes **Explain:** _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits - Choose all that apply.

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- ☐ No current exercises
- ☐ Exercises daily
- ☐ Exercises 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

MEN'S HEALTH

Do you have pain or lump in scrotum or testicles?

☐ Yes ☐ No

Do you have an impaired libido (sex drive)?

☐ Yes ☐ No

Do you have discharge from your penis?

☐ Yes ☐ No

Do you have prostate issues?

☐ Yes ☐ No

When was your last prostate exam?

☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a prostate exam
☐ Prefers not to answer or don't know

When was your most recent PSA (Prostate-Specific Antigen) blood test?

☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a PSA blood test
☐ Prefers not to answer or don't know

What was your PSA (Prostate-Specific Antigen) level on your latest test?

☐ Normal or low ☐ Moderate
☐ High ☐ Never had a PSA level done
☐ Prefers not to answer or don't know

WOMEN'S HEALTH

Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Do you experience painful periods?	☐ Yes ☐ No
Do you have irregular cycles?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Do you perform a regular self-breast examination?	☐ Yes ☐ No
Do you take hormone replacement therapy (HRT)?	☐ Yes ☐ No
Do you take oral contraceptives?	☐ Yes ☐ No
When was your last PAP/pelvic exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP or pelvic exam ☐ Prefers not to answer or don't know
	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram exam ☐ Prefers not to answer or don't know
What was the date of your last menstrual period? (only answer if still menstruating)	☐ Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ Postmenopausal ☐ Have not yet begun menstruation ☐ Prefers not to answer or don't know

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ **Date:** ____ / ____ / _____