**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT INFORMATION FORM**

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|  | Today’s Date: | Date of Birth: |
| Name: | [ ]  Male☐Female | Age: | [ ] Married☐Divorced | [ ] Single☐Separated | [ ] Widowed☐\_\_\_\_\_\_\_\_ |
| Address: | City: | State: | Zip: |
| Home Phone: | Cell: | Fax: |
| Social Security #: | Driver’s License: | State: | Email Address: |
| Spouse’s Name: | Ages of Children: | Occupation/Job Title: |
| Employer/Business Name: | Business Address: |
| Business Phone: | Type of Work: |
| How Did You Hear About Us? |
| emergency Contact: | Phone #: |
| **Insurance** | Address: | Relationship: |
| Who Is Responsible For Your Bill? | [ ] Self[ ] Worker’s Comp | [ ] Auto InsuranceMedicare | [ ] Medicaid[ ] Other (Be Specific): |
| Personal Health Insurance Carrier: | Health ID Card #: |
| Insured Person’s Name: | Primary Care Physician: |
| Insured Person’s Social Security #: | Pharmacy: |
| **Current Health Condition** |
| **Please Circle Areas of Discomfort** | **Chief Complaint: (Why Are You HERE Today?)** |
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| Body Area Involved: | [ ] Cervical (Neck)[ ] Spine (Mid-Back), Ribs, Pelvis (Low Back) | [ ] Upper Extremity (Arms, Wrist, Hands)[ ] Lower Extremity (Legs, Feet, Toes) |
| Condition: | [ ] New[ ] Recurring | [ ] Exacerbation[ ] Chronic |
| Mechanism of Onset: | [ ] Auto[ ] Work | [ ] Fall[ ] Lifting | [ ] Over Exertion[ ] Repetitive Motion | [ ] Unknown[ ] Slept Wrong | [ ] Slip or Fall[ ] No Injury | [ ] Other |
| Symptoms: | [ ] Pain[ ] Numbness | [ ] Stiffness[ ] Weakness |  |  |  |  |
| Location: | [ ] Left[ ] Right | [ ] Bilateral |  |  |  |  |
| Quality: | [ ] Burning[ ] Diffuse | [ ] Dull/Aching[ ] Localized | [ ] Sharp[ ] Shooting | [ ] Stabbing[ ] Throbbing | [ ] Tightness[ ] Tingling | [ ] Radiating[ ] Other |
| On A Scale of 0-10, (10 Being the Worst) Rate Your Symptoms (Resting): | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| On A Scale of 0-10, (10 Being the Worst) Rate Your Symptoms (With Activity): | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Duration: Symptom(s) Started: |
| Symptom(s) Worsened: |
| Symptom(s) Last Occurred: |
| Symptom(s) Last Episode: |
| Injury Occurred: |
| Accident Occurred: |
| Timing Worse In The: | [ ] Morning | [ ] Afternoon | [ ] Night | [ ] W/Activity | [ ] Constant | [ ] Intermittent |
| Associated Signs & Symptoms: | [ ] Blurred [ ] Vision[ ] Depression[ ] Dizziness | [ ] Headaches[ ] Irritability/Mood Swing[ ] Localized Tingling | [ ] Nausea[ ] Radiating[ ] Ringing In Ears | [ ] Sleep[ ] Disturbance[ ] Stiffness |
| Quality Of Headaches: | [ ]  Dull[ ]  Sharp | [ ] Throbbing[ ] Stabbing | [ ] Aura[ ] No Aura | [ ] Radiation:[ ] Weakness: | [ ] Left[ ] Left | [ ] Right[ ] Right | [ ] Bilateral[ ] Bilateral |
| Other Assoc. Signs & Symptoms: | [ ] Aches [ ] Cold Limb[ ] Dizziness[ ] Fatigue  | [ ] Fever [ ] Heartburn[ ] Muscle Spasm[ ] Nausea | [ ] Numbness [ ] Pale Bluish Skin[ ] Panic[ ] Pins & Needles | [ ] Runny Nose [ ] Stiffness[ ] Sweating[ ] Swelling | [ ] Tingling [ ] Vomiting[ ] Weakness |
| Modifying Factors – Symptoms Better With: | [ ] Activity[ ] Bending | [ ] Cold[ ] Heat | [ ] Massage[x] Movement | [ ] OTC Meds[ ] RX Meds | [ ] Rest☐Stretching | [ ] Sitting☐Standing | [ ] Twisting☐Walking | [ ] Nothing  Helps |
| Since Condition Began, Has Anything Permanently Helped You? | [ ] Yes[ ] No |
| Has Anything That You Have Done, Thus Far, Fixed Your Problem | [ ] Yes[ ] No |
| **Employment** |
| Occupation: | Work (Hrs/Day): |
| Job Classification: | [ ] Sitting | [ ] Light | [ ] Moderate | [ ] Heavy Lifting | Lifting Frequency: | [ ] Constant (66-100% Day) | [ ] Frequent (33-65% Day) | [ ] Occasional (0-32% Day) |
| Work Activity Postures: (Hrs/Day) | [ ] Sitting[ ] Standing | [ ] Walking[ ] Climbing | [ ] Pushing[ ] Pulling | [ ] Kneeling[ ] Reaching | [ ] Twisting[ ] Bending |
| Repetitive Activities: (Hrs/Day) | [ ] Computer[ ] Phone | [ ] Machinery[ ] Hand Tools | [ ] Assembly[ ] Grasping |
| How Does This Condition Effect Job Performance: | [ ] Mild Painful (Can Do)[ ] Moderate Painful (Limited) | [ ] Severe (Unable To Perform)[ ] Other (Explain) |

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| Daily Activities: On A Scale Of 0-10, To What Level Are You Experiencing Symptoms While Performing These Activities |
| Activity (Check applicable column) | **0****No Effect** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10****Unable to do** |
| Bending: |  |  |  |  |  |  |  |  |  |  |  |
| Care –Infirm Family: |  |  |  |  |  |  |  |  |  |  |  |
| Carrying Groceries: |  |  |  |  |  |  |  |  |  |  |  |
| Change Pos.–Sit-Stand:  |  |  |  |  |  |  |  |  |  |  |  |
| Climb Stairs: |  |  |  |  |  |  |  |  |  |  |  |
| Driving:  |  |  |  |  |  |  |  |  |  |  |  |
| Extended Computer Use:  |  |  |  |  |  |  |  |  |  |  |  |
| Feeding:  |  |  |  |  |  |  |  |  |  |  |  |
| Household Chores:  |  |  |  |  |  |  |  |  |  |  |  |
| Kneeling: |  |  |  |  |  |  |  |  |  |  |  |
| Lift Children: |  |  |  |  |  |  |  |  |  |  |  |
| Lifting: |  |  |  |  |  |  |  |  |  |  |  |
| Pet Care: |  |  |  |  |  |  |  |  |  |  |  |
| Reading (Concentration):  |  |  |  |  |  |  |  |  |  |  |  |
| Self Care: |  |  |  |  |  |  |  |  |  |  |  |
| Self Care–Bathing:  |  |  |  |  |  |  |  |  |  |  |  |
| Self Care–Dressing: |  |  |  |  |  |  |  |  |  |  |  |
| Self Care–Shaving:  |  |  |  |  |  |  |  |  |  |  |  |
| Sexual Activities:  |  |  |  |  |  |  |  |  |  |  |  |
| Sleep:  |  |  |  |  |  |  |  |  |  |  |  |
| Static Sitting: |  |  |  |  |  |  |  |  |  |  |  |
| Static Standing: |  |  |  |  |  |  |  |  |  |  |  |
| Walking: |  |  |  |  |  |  |  |  |  |  |  |
| Yard Work:  |  |  |  |  |  |  |  |  |  |  |  |

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| **Below is a list of diseases that may seem unrelated to the purpose of your appointment.** **However, these questions must be answered carefully as the problems can affect your overall course of care.** **REVIEW OF SYMPTOMS – Please fill out all of the sections, even if “DENY”** |
| Constitutional: [ ] I Deny Any Const. Issue(s) | [ ] Chills[ ] Night Sweats | [ ] Weight Gain[ ] Weight Loss | ☐Fatigue☐Fever | ☐Daytime Somnolence (Drowsiness) |
| Eye/Vision: [ ] I Deny Any Eye/Vision Issue(s) | [ ] Blindness[ ] Double Vision | [ ] Eye Pain[ ] Photophobia | [ ] Tearing[ ] Blurred Vision | [ ] Field Cuts(Visual Field Defect) | [ ] Cataracts[ ] Glaucoma | [ ] Change In Vision[ ] Itching (Around Eyes) | [ ] Wear Glasses And/Or[ ] Contact Lenses |
| Ears, Nose, & Throat: [ ] I Deny Any E/N/T Issue(s) | [ ] Bleeding[ ] Discharge[ ] Dizziness[ ] Snoring | [ ] Fainting[ ] Headaches[ ] Loss of Smell[ ] Sore Throats (Frequent) | [ ] Nasal Congestion[ ] Sinus Infections[ ] Dental Implants | [ ] Ear Drainage[ ] Ear Infection(s)[ ] Hearing Loss[ ] Tinnitus (Right in Ears) | [ ] Post Nasal Drip[ ] Difficulty Swallowing[ ] Ear Pain | [ ] Hoarseness[ ] Rhinorrhea (Runny Nose)[ ] Sinus Infections[ ] TMJ Problems |
| Respiration: [ ] I Deny Any Respiratory Issue(s) | [ ] Asthma | [ ] Coughing Up Blood | [ ] Sputum Production | [ ] Cough | [ ] Shortness of Breath | [ ] Wheezing |
| Cardiovascular:[ ] I Deny Any CARDIO. Issue(s) | [ ] Angina (Chest Pain or Discomfort)[ ] Chest Pain[ ] Claudication (Leg Pain or Achiness) | [ ] Heart Murmur[ ] Heart Problems[ ] Orthopnea (Difficulty Breathing While Lying Down) | [ ] Palpitations (Irregular Or Forceful Breathing of the Heart)[ ] Paroxysmal Nocturnal Dyspnea (Waking At Night With Shortness of Breath) | [ ] Swelling of Legs[ ] Ulcers[ ] Varicose Veins |
| Gastrointestinal: [ ] I Deny Any GI Issue(s) | [ ] Abdominal Pain[ ] Belching[ ] Black, Tarry Stools[ ] Constipation | [ ] Diarrhea[ ] Difficulty Swallowing[ ] Heartburn[ ] Hemorrhoids | [ ] Indigestion[ ] Jaundice (Yellowing of Skin)[ ] Nausea[ ] Rectal Bleeding | [ ] Abnormal Stool Caliber (Quality)[ ] Abnormal Stool Color[ ] Abnormal Stool Consistency | [ ] Vomiting Blood☐VOMITING |
| Female: [ ] I Deny Any Female Issue(s) | [ ] Birth Control Therapy[ ] Breast Lump/Pain[ ] Burning Urination | [ ] Cramps[ ] Frequent Urination[ ] Hormone Therapy | [ ] Irregular Menstruation[ ] Urine Retention[ ] Vaginal Bleeding | [ ] Vaginal Discharge |
| Male: [ ] I Deny Any Male Issue(s) | [ ] Burning Urination[ ] Prostate Problems | [ ] Erectile Dysfunction | [ ] Frequent Urination[ ] Urination Retention | [ ] Hesitancy/Dribbling |
| Endocrine: [ ] I Deny Any Endocrine Issue(s) | [ ] Cold Intolerance[ ] Diabetes | [ ] Excessive Appetite[ ] Excessive Hunger | [ ] Excessive Thirst[ ] Frequent Urination | [ ] Goiter[ ] Hair Loss | [ ] Heat Intolerance[ ] Unusual Hair Growth | [ ] Voice Changes |
| Skin: ☐I Deny Any Skin Issue(s) | [ ] Changes in Nail Texture[ ] Changes in Skin Color | [ ] Hair Growth[ ] Hair Loss | [ ] Hives[ ] Itching | [ ] Paresthesia (Numbness, Prickling, or Tingling) | [ ] Rash[ ] History of Skin Disorders | [ ] Skin Lesions /Ulcers[ ] Varicosities |
| Nervous Systems: [ ] I Deny Any NS Issue(s) | [ ] Dizziness[ ] Facial Weakness | [ ] Headaches[ ] Limb Weakness | [ ] Loss of Consciousness[ ] Loss of Memory | [ ] Numbness[ ] Seizures | [ ] Sleep Disturbance[ ] Stress | [ ] Strokes[ ] Tremors | [ ] Unsteadiness of Gait |
| Psychological: [ ] I Deny Any Psychological Issue(s) | [ ] Anhedonia (Inability to Experience Joy or Enjoy Life) | [ ] Anxiety[ ] Appetite Changes | [ ] Behavioral Change(s)[ ] Bipolar Disorder | [ ] Confusion[ ] Convulsions | [ ] Depression[ ] Insomnia | [ ] Memory Loss[ ] Mood Changes |
| Allergy: [ ] I Deny Any Allergy Issue(s) | [ ] Anaphylaxis (History of Sneezing) | [ ] Food Intolerance | [ ] Itching[ ] Nasal Congestion | [ ] Sneezing |
| Hematology: [ ] I Deny Any Hematology Issue(s) | [ ] Anemia[ ] Bleeding | [ ] Blood Clotting[ ] Blood Transfusion(s) | [ ] Bruises Easily[ ] Fatigue | [ ] Lymph Node Swelling |
| **Past Health History – Please fill out carefully as these problems can affect your overall course of care.** |
| Childhood Illness:[ ] I Deny Any Childhood Illness(es) | [ ] Add[ ] Allergies/HayFever[ ] Asthma[ ] Atopic Dermatitis (Eczema) | [ ] Bed Wetting[ ] Cerebral Palsy[ ] Chicken Pox[ ] Depression | [ ] Diabetes[ ] Ear Infections[ ] Fetal Drug[ ] Exposure | [ ] Food Allergies[ ] Headaches[ ] Hepatitis[ ] HIV | [ ] Measles[ ] Mumps[ ] Rash[ ] Scoliosis | [ ] Seizure Disorder[ ] Sickle cell Anemia[ ] Spina Bifida[ ] Other (Please Describe) |
| Adult Illness:[ ] I Deny Any Adult Illness(es)  | [ ] Alzheimers[ ] Anemia[ ] Arthritis[ ] Asthma[ ] Cancer[ ] Chicken Box[ ] Chron’s/Colitis[ ] CRPS (RSD) | [ ] CVA (Stroke)[ ] Cystic Kidney Disease[ ] Depression[ ] Diabetes (Insulin)[ ] Diabetes (Non Insulin)[ ] Ear Infections (Frequent)[ ] Emphysema[ ] Eye Problems | [ ] Fibromyalgia[ ] Heart Disease[ ] Hepatitis[ ] HIV[ ] Hypertension[ ] Influenza Pneumonia[ ] Liver Disease[ ] Lung Disease | [ ] Lupus Erythema (Discoid)[ ] Lupus Erythema (Systemic)[ ] Multiple Sclerosis[ ] Parkinson’s Disease[ ] Pleurisy[ ] Pneumonia[ ] Psychiatric Problems[ ] Scoliosis | [ ] Seizure Disorder[ ] Shingles[ ] STD’s (Unspecified)[ ] Suicide Attempt(s)[ ] Thyroid Problems[ ] Vertigo[ ] Past History of Similar Symptoms To Your Current Condition |
|  | [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Surgeries:☐I Deny Any Surgery (ies) | [ ] Angioplasty[ ] Appendectomy[ ] Caesarean Section[ ] Cardiac Catheterization[ ] Carpal Tunnel Repair | [ ] Coronary Artery Bypass[ ] Cosmetic[ ] D & C[ ] Dental Surgery☐Gall Bladder | [ ] Hemorrhoidectomy[ ] Hernia Repair[ ] Hysterectomy[ ] Joint Reconstruction☐Joint Replacement | [ ] Laminectomy[ ] Mastectomy[ ] Pacemaker Insertion[ ] Rotator Cuff[ ] Spinal Fusion | [ ] Tonsillectomy[ ] Other |
| OB/GYN:☐I Deny Any OB/GYN Issues | [ ] I have never been pregnant[ ] I have been pregnant in the past[ ] I am currently pregnant | **Menstrual History:**Age of Onset \_\_\_\_\_ | [ ] My Menses Is Regular[ ] My Menses Is Irregular[ ] I Am Currently In Menopause | Date of Last Menses \_\_\_/\_\_\_/\_\_\_ |
| Injuries:☐I Deny Any Injury (ies) | [ ] Back Injury[ ] Broken Bones[ ] Severe Fall | [ ] Fracture[ ] Disability[ ] Head Injury | [ ] Industrial Accident[ ] Joint Injury[ ] Severe Laceration | [ ] Motor Vehicle Accident[ ] Mild/Moderate Soft Tissue Injury[ ] Severe Soft Tissue Injury |
| Immunizations:☐I Deny Any Immunization(s) | [ ] DTaP (Diptheria, Tetanus & Pertussis) | [ ] Flu[ ] Hepatitis A[ ] Hepatitis B | [ ] Hepatitis C[ ] Influenza[ ] IPV (Polio) | [ ] MMR (Measles, Mumps, & Rubella)[ ] Pneumococcal[ ] PPD (Mantoux Test-TB) | [ ] Small Pox[ ] TB[ ] Varivax (Chicken Pox) | [ ] Whopping Cough (Pertussis) |
| Non-Drug Allergies:☐I Deny Any Non-Drug Allergies | [ ] Animals | [ ] Dairy | [ ] Eggs | [ ] Food Coloring | [ ] Mold | [ ] Pollen |

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| **Previous Treatment** |
| Previous Chiropractic Care? | [ ] Yes If Yes, Who? (Name)[ ] No |
| Have You Seen Other Doctors for this Condition? | [ ] Yes If Yes, Who? (Name)[ ] No | Location of Office: | Type of Treatment: |
| Were You Sastified with the results of your treatment? | [ ] Yes Explain:[ ] No |
| aRE YOU cURRENTLY tAKING anY pRESCRIPTION mEDICATIONS? | [ ] Yes iF yES, pLEASE mARK OR lIST (bE sPECIFIC)[ ] No | [ ] aLLERGY mEDICATION[ ] antI-dEPRESSANTS | [ ] bLOOD pRESSURE mEDS.[ ] iNSULIN | ☐mUSCLE rELAXERS☐NERVE PILLS | [ ] pAIN kILLERS[ ] oTHER (PLEASE sPECIFY) |
| dO yOU wEAR aNY oF tHE fOLLOWING? | [ ] hEAL lIFTS[ ] iNNER sOLES | [ ] aRCH sUPPORTS[ ] oRTHOTICS | pLEASE lIST aNY oTHER cONDITIONS yOU fEEL wE sHOULD kNOW aBOUT – eVEN IF uNRELATED |
| **fAMILY hISTORY – eNTER iNITIALS bELOW: a = aLIVE d = dECEASED** |
| \_\_\_ gENERAl fAMILY\_\_\_ faTHER | \_\_\_ mOTHER\_\_\_ pATERNAL gRANDFATHER | \_\_\_ pATERNAL gRANDMOTHER\_\_\_ mATERNAL gRANDFATHER | \_\_\_ mATERNAL gRANDMOTHER\_\_\_ sON(S) | \_\_\_ dAUGHTER(S)\_\_\_ bROTHER(S) | \_\_\_ sISTER(S) |
|  **nAME**  | **rELATION** | **pAST & pRESENT hEALTH pROBLEMS** |
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|  |  |  |
| **sOCIAL hISTORY** |
| **aLCOHOL:** | [ ] nEVER[ ] dAILY[ ] wEEKLY[ ] mONTHLY | [ ] sOCIAL cONSUMPTION oNLY | ☐bEER☐lIQOUR☐WINE | oz.’S # gLASSES | **dIET:**mARK ALL THAT aPPLY | [ ] hIGH fAT[ ] hIGH fIBER[ ] hIGH pROTEIN[ ] hIGH sALT | [ ]  low cALORIE[ ]  lOW cARB☐ LOW SUGAR | [ ]  low fIBER[ ]  lOW sALT |
| **dRUGS:** | [ ]  dENY aNY iLLEGAL dRUG uSE[ ]  dENY uSE OF iv dRUGS | [ ]  hAVE nOT uSED dRUGS sINCE \_\_\_\_\_[ ]  hAVE uSED dRUgS fOR \_\_\_\_\_ | **tOBACCO:** | [ ]  dENY tOBACCO use[ ]  lIVE W/A sMOKER[ ]  qUIT sMOKING | # pER:\_\_\_ | [ ]  dAY[ ]  wEEK☐ MONTH | ☐ # CHEW\_\_\_\_ |
| **pLEAE rEAD cAREFULLY aND sIGN bELOW** |
| I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that chiropractic clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to chiropractic clinic will be credited to my account upon receipt. However I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. |
| **Guardian or Spouse’s Signature of Authorizing care:**(Signature Indicates Consent To Treat) | **Date:** |
| **Patient (Print Name):** | **Patient’s Signature:** | **Date:** |