

# Welcome

## Patient Information

Date \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

Cell Phone \_\_\_\_\_ email \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_

Phone \_\_\_\_\_

Nearest friend not living with you \_\_\_\_\_

Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Landlord \_\_\_\_\_ Phone \_\_\_\_\_

No. of Children \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Phone \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

I will be paying today by  cash  check  credit card

In understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent (if minor) \_\_\_\_\_ Date \_\_\_\_\_

## In Case of Emergency Contact

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

## Accident Information

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching

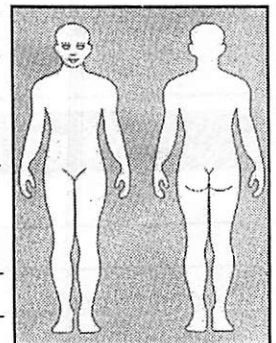
Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# Patient History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

|                     |                              |                             |                  |                              |                             |                      |                              |                             |                    |                              |                             |
|---------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| AIDS/HIV            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anexoria            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Beeding Disorders   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____        |                              |                             |
| Cataracts           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                    |                              |                             |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                    |                              |                             |
| Chicken Pox         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |                              |                             |                    |                              |                             |
| Diabetes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |                              |                             |                    |                              |                             |
|                     |                              |                             | Headaches        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |                              |                             |                    |                              |                             |

## EXERCISE

- None
- Moderate
- Daily
- Heavy

## WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

## HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day \_\_\_\_\_  
 Drinks/Week \_\_\_\_\_  
 Cups/Day \_\_\_\_\_  
 Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

| Injuries/Surgeries you have had | Description | Date  |
|---------------------------------|-------------|-------|
| Falls                           | _____       | _____ |
| Head Injuries                   | _____       | _____ |
| Broken Bones                    | _____       | _____ |
| Dislocations                    | _____       | _____ |
| Surgeries                       | _____       | _____ |

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

|                      |       |       |
|----------------------|-------|-------|
|                      |       |       |
|                      |       |       |
| Pharmacy Name _____  | _____ | _____ |
| Pharmacy Phone _____ | _____ | _____ |