PATIENT INFORMATION

Date: _____ E-mail address: _____
Name: _____ Referred By: _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
Birth Date: _____ Sex: _____Age: _____ Marital Status: _____ # of Children: _____
Occupation: _____ Employment: _____ Work Phone #: _____
Social Security #: _____ Driver's License #: _____

PLEASE FILL IN THE APPROPIATE SPACES (All information you give is confidential)

MAJOR COMPLAINT: _____
_____
How long have you had this condition?_____
Date began: _____ Have you lost work days: Yes ( ) No ( ) How many?_____
Have you had this similar condition before? Yes ( ) No ( ) When? _____
Was the injury related to: Work accident ( ) Auto accident ( )
When did you last see a Chiropractor? _____ Dr.: _____
Why did you see this Chiropractor? _____ Where you helped? _____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____
_____
Did you follow it? _____ if not, why?_____
Why are you changing Chiropractors?_____

MARK THE PRESENT CONDITIONS BELOW WITH AN X AND THE PAST CONDITIONS WITH AN O.

___ Fractured Bones
___ Auto Accidents
(a) ___ 0-1 years ago
(b) ___ 1-5 years ago
(c) ___ More than 5 years ago
___ Other Accidents/Falls
___ Knocked Unconscious
___ Back Curvature
___ Mental or Emotional Disorder
___ Arthritis
___ Diabetes
___ Swollen or Painful Joints
___ Convulsions/Epilepsy
___ Skin Problems
___ Itching
___ Bruise Easily
___ Cancer
___ Frequent Cold/Flu
___ Nervous
___ Tension
___ Depressed
___ Irritable
___ Anemia
___ Excess Sweating
___ Tremors
___ Light Bothers Eyes
___ Allergy
___ Sinus Problems
___ Light Headed Upon Rising
___ Under Stress
___ Crave Sweets or Salt
___Eating Disorders
___ Trouble Sleeping
___ Trouble Concentrating

___ Learning Disability
___ Mistake Sidedness (R. from L.)
___ Stutter
___ Dyslexia
___ Mood Changes
___ Lose Temper Easily
___ Headache
___ Neck Pain or Stiff R. L.
___ Numbness, Tingling, or Pain in Arms, Hands, Finger R. L.
___ Jaw Pain or Click (T.M.J.) R.L.
___ Head Seems to Heavy
___ Head & Shoulders Feel Tired
___ Difficulty in Excessive (Standing, Walking, Sitting, Riding, Bending, Lifting, Twisting, Household Duties)
___ Shoulder Pain R.L.
___ Dizziness
___ Ringing in Ears R.L.
___ Hearing Loss R.L.
___ Fainting
___ Loss Balance
___ Blurred or Double Vision R.L.
___ Upper Back or Stiffness R.L.
___ Mid Back or Stiffness R.L.
___ Lower Back Pain or Stiffness R.L.
___ Numbness, Tingling or Pain in Buttocks, Thighs, Legs, Feet, Toes R.L.
___ Pain with Cough, Sneeze or Strain at Stools
___ Hip Pain R.L.
___ Foot Trouble R.L.
___ Chest Pain
___ Asthma
___ Lung Problems

___ Wheezing
___ Heath Problems
___ Stroke
___ High or Low Blood Pressure
___ Varicose Veins
___ Liver Trouble
___ Gall Bladder Trouble
___ Digestive Problems
___ Excessive Gas
___ Belching/Bloating After Meals
___ Heartburn
___ Ulcers
___ Diarrhea/Constipation
___ Colon Trouble
___ Hemorrhoids
___ Prostate Problems
___ Impotence
___ Kidney Trouble
___ Kidney Stones
___ Frequent Urination
___ Discharge
___ Menstrual Problems/PMS
___ Menopausal Problems
___ Brest Lumps, Soreness, Discharge
___ Pregnant (Now)
___ Bedwetting
___ Ear Infection
___ Hepatitis
___ Venereal Disease
___ AIDS/HIV
_____
_____
_____