Patient Name: Date:

Personal Status

Relationships: a. single b. married c. partnered d. separated e. divorced f. widowed	Education: a. high school b. vocational school c. college d. graduate school	Exercise: a. never b. occasional c. 3-5 times / wk. d. daily
Tobacco Use: a. none b. occasional c. light d. medium e. heavy	Alcohol Use: a. never b. 1 time / week c. 2-5 times a week d. daily	Caffeine Use: a. never b. occasional c. light d. medium e. heavy

Initial Primary Complaint

Description: (circle only 1, there will be another area for secondary complaints) a. neck pain b. low back pain c. leg pain R / L d. mid back pain e. arm pain R / L f. headache g. other:_____	Severity: a. mild b. moderate c. severe Frequency: a. constant (100%) b. frequent (50-75%) c. intermittent (25-50% d. occasional (25%)	Symptom duration: a. continuous b. days c. hours d. minutes e. seconds f. weeks Interferes with daily living activities: a. constant b. frequent c. none d. occasional e. slight
Causation: a. accident b. illness c. unknown d. vehicle accident e. work Symptom Status; a. improving b. unchanged c. worsening	Please rate the Pain Level: **0 is no pain, 10 is severe pain** or the worst pain you've ever felt. If your pain varies from day to day, please circle two numbers to indicate the range. 0 1 2 3 4 5 6 7 8 9 10	Onset: (circle any or all that apply) a. date: _____ b. chronic c. unknown
Quality, Discription: a. aching b. burning c. dull d. gripping e. numb f. sharp g. shooting h. tender i. throbbing j. tingling k. weak	Exacerbating Factors: a. bending b. exercise c. lifting d. lying down e. nothing f. reaching g. sitting h. standing i. walking j. working	Relieving Factors: a. bending b. cold c. heat d. lying down e. nothing f. OTC meds g. prescription meds h. resting i. sitting j. standing

Initial *Seconday* Complaint (skip if not applicable)

Description: (circle only 1 secondary complaint) h. neck pain i. low back pain j. leg pain R / L k. mid back pain l. arm pain R / L m. headache n. other: _____	Severity: d. mild e. moderate f. severe Frequency: e. constant (100%) f. frequent (50-75%) g. intermittent (25-50% h. occasional (25%)	Symptom duration: g. continuous h. days i. hours j. minutes k. seconds l. weeks Interferes with daily living activities: f. constant g. frequent h. none i. occasional j. slight
Causation: f. accident g. illness h. unknown i. vehicle accident j. work Symptom Status: a. improving b. unchanged c. worsening	Please rate the Pain Level: **0 is no pain, 10 is severe pain or the worst pain you've ever felt.** If your pain varies from day to day, please circle two numbers to indicate the range. 0 1 2 3 4 5 6 7 8 9 10	Onset: (circle any or all that apply) d. date: _____ e. chronic f. unknown
Quality, Description: l. aching m. burning n. dull o. gripping p. numb q. sharp r. shooting s. tender t. throbbing u. tingling v. weak	Exacerbating Factors: k. bending l. exercise m. lifting n. lying down o. nothing p. reaching q. sitting r. standing s. walking t. working	Relieving Factors: k. bending l. cold m. heat n. lying down o. nothing p. OTC meds q. prescription meds r. resting s. sitting t. standing

Third Complaint: _____ rate pain : 0 1 2 3 4 5 6 7 8 9 10

Fourth Complaint: _____ rate pain : 0 1 2 3 4 5 6 7 8 9 10

Work Status

Job Title:	Hire Date:	# days / week:	#hrs / day

Work Status: a. full time unrestricted b. full time restricted c. part time unrestricted d. part time restricted e. not working	Date Stopped (if applicable): _____ Date Returned (if applicable): _____	Stopped by (if applicable): a. attorney b. doctor c. employer d. self their name: _____

Notes: _____

Initial Complaint Related Medical History:

OTC Meds: _____

Exam:

Physician: _____ Date: _____ Diagnosis: _____

Prescription Med's: _____

When taken: _____ Perceived Effectiveness: _____

Diagnostics: _____

By Whom: _____ Date: _____ Results: _____

_____

Treatments: _____

By Whom: _____ Date: _____ Results: _____

_____

Surgery: _____

By Whom: _____ Date: _____ Results: _____

_____

When did you last see a chiropractor? _____ Where you helped? Y / N

If you are changing chiropractors, why? _____

Health History

Place a *check mark* on the areas that are present, or a (P) on areas that you've experienced in the past:

__heart attack	__stroke	__arthritis	__gall bladder trouble
__diabetes	__glaucoma	__fainting spells	__kidney stones
__difficult urination	__bloody stools	__difficulty w/ bowel movements	__asthma
__prostate trouble	__anemia	__cancer	__menstrual cramping
__AIDS (or HIV)	__ulcers	__diverticulosis	__shortness of breath
__dizziness	__memory loss	__chest pain	__sudden weight loss
__constipation	__diarrhea	__general fatigue	__loss of hearing
__nausea	__muscle cramping	__soreness of joints	__epilepsy
__ears ringing	__headache	__migraines	__ sprained ankle L or R
__gout	__tuberculosis	__syphilis	__broken bones: specify _____
__hip / knee replacement			

General Activities

__sleep on waterbed	__read in bed	__fall asleep on recliner / couch
__sleep on stomach	__needle point / knitting	__use 2 or more pillows to sleep
__sewing	__lift weights	__play video games __ hrs/day
__exercise __ x/wk	__jog__x's/week	__computer use __hrs / day
__swim	__squats	__watch TV __ hrs / day
__sit ups		

Do you take nutritional supplements? Y / N If yes, what? _____

Please add anything else you would like the doctor to know:

_____

_____

Authorization:

I certify that I have read and understand the previous information to the best of my knowledge. The questions presented have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including diagnosis and the records of any care or examination rendered to me or my child during the period of such chiropractic care to third party payers and or health practitioners. I authorize and request my insurance company pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's signature:_____ Date: _____

Confidential Patient Information

(Please Print – Front & Back)

1. Patient Information Date:_____

Last Name First Name M.I. Nick Name

Address City State Zip Code

Home #: _____ Work#:_____ Cell#: _____

Email Address: _____

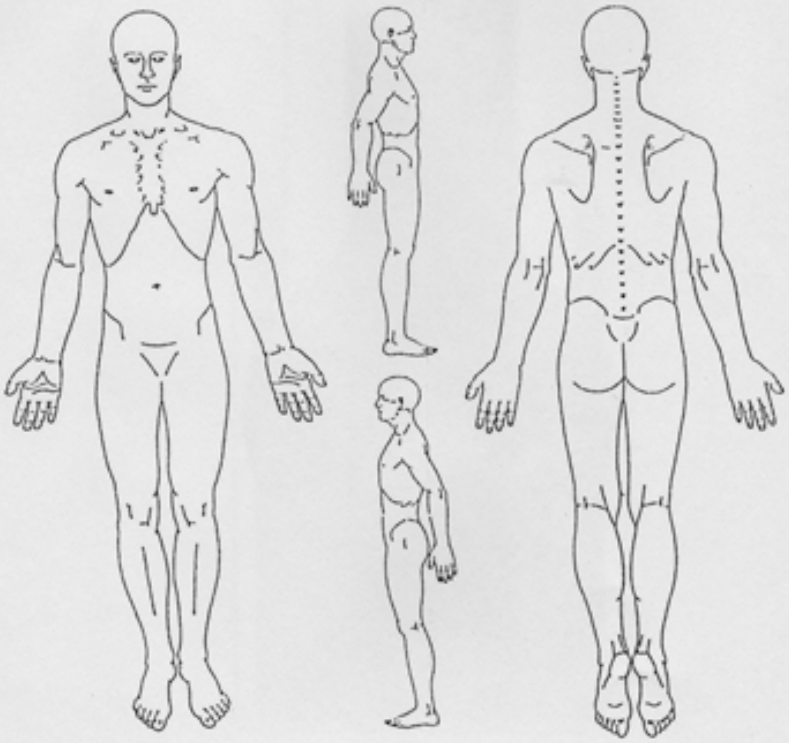
Social Security # :_____ Date of Birth.:_____ sex: [ ] M [ ] F

Height: _____Weight:_____ Occupation:_____ Employer: _____

Spouse: _____Employer:_____

If you are experiencing pain or unusual sensations please indicate on the pictures below:

KEY

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER

DATE _____