

Confidential Patient Data

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____
Social Security #: _____ Age: _____ Male Female
Marital Status: Married Single Divorced Separated Other _____
Name of Spouse or Nearest Relative: _____ Phone: _____
Your Occupation _____ Your Employer: _____

REFERRED TO THIS OFFICE BY: Friend/Family Member – Name? _____

Clinic Location Clinic Website Insurance website Google/Yahoo Search

Angie's List Yellow Pages Other _____

➤ Would you like us to notify your primary care physician of your treatments here? yes no

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	Other _____		

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

Please list any medications you may be taking: _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

ACCIDENT HISTORY : Job Auto Other 1. _____ Date: _____
 Job Auto Other 2. _____ Date: _____
 Job Auto Other 3. _____ Date: _____

Are both of your parents still alive? Yes No (please explain cause(s) death below) example (heart attack):

Your Kids None Boys; Ages _____ Girls; Ages _____

Please Describe Your Present Conditions:

Body Area _____ (example: low back, neck, headache)
Please Circle Best Responses From Each Line Below

Pain Level: 1 2 3 4 5 6 7 8 9 10 (1 is least, 10 is worst)
Mild - Mild to Moderate - Moderate - Moderately Severe - Severe
Constant - Occasional - Intermittent - Frequent

Body Area _____ (example: low back, neck, headache)
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Please Check All Activities That Are Worsened By Your Present Condition

General

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Chewing | <input type="checkbox"/> Getting In/Out of Vehicle | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting Children | <input type="checkbox"/> Reading | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Sexual Intercourse | <input type="checkbox"/> Running | <input type="checkbox"/> Bending | <input type="checkbox"/> Lying in Bed | <input type="checkbox"/> Using Computer |
| <input type="checkbox"/> Exercising | <input type="checkbox"/> Sitting in Recliner | | | |

Housework

- | | | | | |
|---|--|------------------------------------|---|----------------------------------|
| <input type="checkbox"/> Doing Laundry | <input type="checkbox"/> Making Beds | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Washing Dishes | <input type="checkbox"/> Ironing |
| <input type="checkbox"/> Carrying Groceries | <input type="checkbox"/> Caring for Pets | <input type="checkbox"/> Cooking | <input type="checkbox"/> Sweeping | |

Yard Work

- | | | |
|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Mowing Lawn | <input type="checkbox"/> Raking Leaves | <input type="checkbox"/> Gardening |
|--------------------------------------|--|------------------------------------|

Personal Grooming

- | | | |
|---------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Combing Hair | <input type="checkbox"/> Shaving | <input type="checkbox"/> In/Out of Bathtub |
|---------------------------------------|----------------------------------|--|

Travel

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Driving | <input type="checkbox"/> Riding as Passenger |
|----------------------------------|--|

PLEASE CHECK THE FOLLOWING THAT **AGGRAVATE** YOUR CONDITION:

- COUGHING SNEEZING STRAINING AT STOOL BENDING CARRYING
 CLIMBING DRIVING EXERCISING GETTING IN/OUT OF BED GETTING IN/OUT OF CAR
 LIFTING PULLING/PUSHING REPETITIOUS MOVEMENTS STANDING
 STOOPING WALKING HEAT COLD

PLEASE CHECK THE FOLLOWING THAT **RELIEVE** YOUR CONDITION:

- CHIROPRACTIC CARE ADVIL TYLENOL ASPIRIN PAIN PILLS MUSCLE RELAXERS
 RECLINING WALKING MASSAGES BY HAND OR VIBRATOR COLD/ICE PACK
 HEAT/HOT PACK HOT SHOWERS/TUB SOAKING HEAT LINIMENT
 MINERAL ICE EXERCISING SLEEPING

Patient's Signature: X Date: _____

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 SYSTEMS- Please fill out all of the sections, even if "DENY"

Constitutional: I.... Deny Any Constitutional Issue (s)

- Chills
- Weight Gain
- Daytime Somnolence (Drowsiness)
- Weight Loss
- Fatigue
- Fever
- Night Sweats

Eyes/Vision: I.... Deny Any Eyes/Vision Issue (s)

- Blindness
- Eye Pain
- Tearing
- Cataracts
- Change in Vision
- Double Vision
- Blurred Vision
- Field Cuts (visual field defect)
- Wears Glasses/Contact Lenses
- Glaucoma
- Itching (around eyes)
- Photophobia

Ears,Nose & Throat: I.... Deny Any Ears, Nose & Throat Issue (s)

- Bleeding
- Headaches
- Snoring
- Ear Drainage
- Nose Bleeds (frequent)
- Dentures
- Hearing Loss
- Tinnitus (Ringing in Ears)
- Ear Pain
- Dizziness
- Nasal Congestion
- Dental Implants
- Head Injury
- Ear Infections
- Post Nasal Drip
- Sinus Infections
- TMJ Problems
- Fainting
- Loss of Smell
- Sore Throats (frequent)
- Discharge
- Rhinorrhea (Runny Nose)
- Difficulty Swallowing
- Hoarseness

Respiration: I.... Deny Any Respiration Issue (s)

- Asthma
- Coughing Up Blood
- Sputum Production
- Cough
- Shortness of Breath
- Wheezing

Gastrointestinal: I.... Deny Any Gastrointestinal Issue (s)

- Abdominal Pain
- Nausea
- Belching
- Rectal Bleeding
- Hemorrhoids
- Constipation
- Vomiting Blood
- Jaundice (Yellowing Skin)
- Difficulty Swallowing
- Abnormal Stool
- Heartburn
- Black, Tarry Stool
- Vomiting
- Indigestion
- Diarrhea
- Abnormal Stool Color

Endocrine: I.... Deny Any Endocrine Issue (s)

- Cold Intolerance
- Voice Changes
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Frequent Urination
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst

Nervous System: I.... Deny Any Nervous System Issue (s)

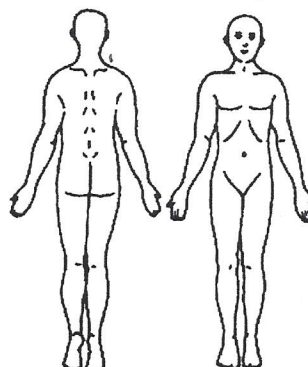
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbances
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait
- Slurred Speech

Allergy: I.... Deny Any Allergy System Issue (s)

- Anaphylaxis (history of)
- Itching
- Food Intolerance
- Nasal Congestion
- Sneezing

Please outline on the diagram the area of your discomfort

A=Aches B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other



Cardiovascular: I.... Deny Any Cardiovascular Issue (s)

- Angina (Chest Pain)
- Claudication (Leg Pain)
- Heart Problems
- Orthopnea (difficulty breathing while lying down)
- Palpitations (irregular or forceful beating of heart)
- Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath)
- Shortness of Breath with Exertion or Exercise
- Ulcers
- Heart Murmur
- Swelling of Legs
- Varicose Veins

Female: I.... Deny Any Female Issue (s)

- Birth Control Therapy
 - Burning Urination
 - Frequent Urination
 - Irregular Menstruation
 - Vaginal Bleeding
 - Breast Lumps/Pain
 - Cramps
 - Hormone Therapy
 - Urine Retention
 - Vaginal Discharge
- Are you pregnant? Yes/No Date of Last Period: _____

Male: I.... Deny Any Male Issue (s)

- Burning Urination
- Prostate Problems
- Frequent Urination
- Erectile Dysfunction
- Urine Retention
- Hesitancy/Dribbling

Skin: I.... Deny Any Skin Issue (s)

- Changes in Nail Texture
- Hair Growth
- Itching
- Rash
- Skin Lesions/Ulcers
- Hair Loss
- Paresthesia (numbness, prickling or tingling)
- History of Skin Disorder
- Varicosities
- Changes in Skin Color
- Hives

Psychologic: I.... Deny Any Psychologic Issue (s)

- Anhedonia
- Confusion
- Depression
- Behavioral Changes
- Bipolar Disorder
- Convulsions
- Appetite Changes
- Mood Changes
- Anxiety
- Insomnia
- Memory Loss

Hematology: I.... Deny Any Hematology Issue (s)

- Anemia
- Blood Transfusion
- Lymph Node Swelling
- Bleeding
- Bruises Easy
- Blood Clotting
- Fatigue

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: YES NO Referred

Doctor's Signature

