

## CONFIDENTIAL PATIENT INFORMATION

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case. Thank you.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

CURRENT ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE : (H) \_\_\_\_\_ (W) \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ STATUS: S M D SPOUSE'S NAME: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ SPOUSE'S DATE OF BIRTH: \_\_\_\_\_

# OF CHILDREN: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

NAME & ADDRESS OF EMPLOYER: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ TEL.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

### HEALTH INFORMATION

Main health concern: \_\_\_\_\_

Other health concerns: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had similar conditions in the past? \_\_\_\_\_

Does this condition affect your work?  Yes  No

Does this condition affect your family or social life?  Yes  No

What aggravates this condition? \_\_\_\_\_

Are you taking any medication? (please specify) \_\_\_\_\_

What helps your symptoms? \_\_\_\_\_

Have you had any surgery, falls or accidents?  Yes  No

When? \_\_\_\_\_ Please describe \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Date of last spinal x-ray \_\_\_\_\_

Have you had previous chiropractic care?  Yes  No

### INSURANCE INFORMATION

Is this condition due to: A work injury  Yes  No An automobile accident  Yes  No

Are you covered by Medicare? ID #: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_

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

Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

### DO YOU SUFFER FROM:

|                            | Yes                      | No                       |
|----------------------------|--------------------------|--------------------------|
| Headache                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm/Shoulder Pain          | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Pain                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Hip or Leg Pain            | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal Pain             | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Trouble              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble              | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitation                | <input type="checkbox"/> | <input type="checkbox"/> |
| Circulatory                | <input type="checkbox"/> | <input type="checkbox"/> |
| High or Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Female Problems            | <input type="checkbox"/> | <input type="checkbox"/> |
| Prostate Disorder          | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Problems            | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder Problems           | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung or Bronchial Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive Disorder         | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation               | <input type="checkbox"/> | <input type="checkbox"/> |
| Loose Stool                | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Joints             | <input type="checkbox"/> | <input type="checkbox"/> |
| Insomnia                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervousness                | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression                 | <input type="checkbox"/> | <input type="checkbox"/> |
| General Fatigue            | <input type="checkbox"/> | <input type="checkbox"/> |
| Morning Fatigue            | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor Memory                | <input type="checkbox"/> | <input type="checkbox"/> |
| Hot Flashes                | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer                     | <input type="checkbox"/> | <input type="checkbox"/> |

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. During the past month, have you been bothered by feeling down, depressed, or hopeless?  YES  NO
2. During the past month, have you often been bothered by little interest or pleasure in doing things?  YES  NO

## CURRENT MEDICAL COMPLAINTS

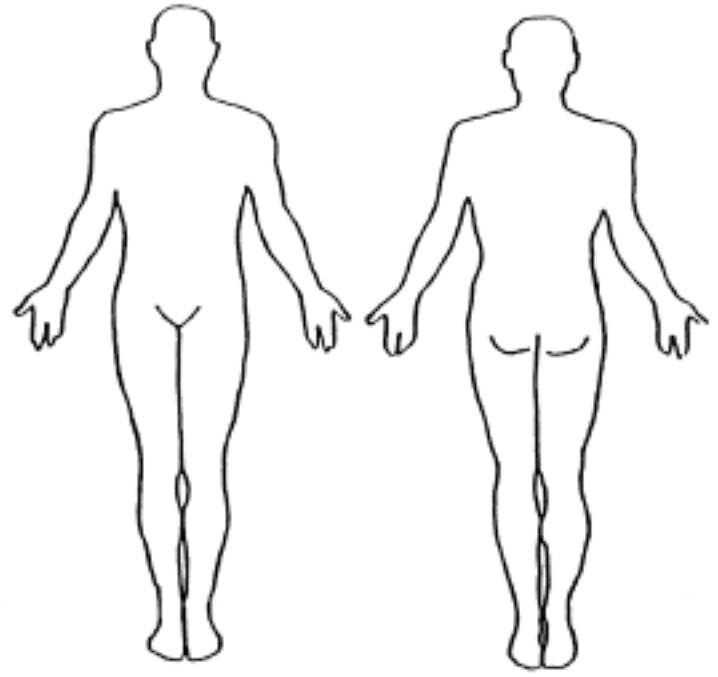
Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing:

SHARP AND STABBING ††††  
 DULL AND ACHY vvvv  
 PINS AND NEEDLES 0000  
 NUMBNESS /////  
 Please describe other medical complaints:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



- Do you experience pain every day?  Yes  No \_\_\_\_\_
- Does your pain wake you up during the night?  Yes  No \_\_\_\_\_
- Does your pain worsen during menses?  Yes  No \_\_\_\_\_

Presently pain is increased when you:

- |                            |  |                  |  |
|----------------------------|--|------------------|--|
| Sit                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Climb            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stand                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Crouch           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rise from the chair        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kneel            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Walk                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Push             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bend                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pull             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rise up from bending       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lift             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crawl                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Repeated lifting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reach above shoulder level | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |  |
| Reach below shoulder level | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |  |

What can you do to relieve pain? \_\_\_\_\_

If you have been treated by others for this condition, please list in order of most recent:

- 1) \_\_\_\_\_ Date: \_\_\_\_\_ City: \_\_\_\_\_
- 2) \_\_\_\_\_ Date: \_\_\_\_\_ City: \_\_\_\_\_
- 3) \_\_\_\_\_ Date: \_\_\_\_\_ City: \_\_\_\_\_

During the past two months has your condition:  Improved  Unchanged  Worsened

Describe how your condition affects at-home responsibilities, recreational activities and lifestyle: \_\_\_\_\_

Do you perform daily neck/back exercises:  Yes  No

Have you participated in a back conditioning and education program?  Yes  No

Are you interested in discussing your participation in such a program?  Yes  No