

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?

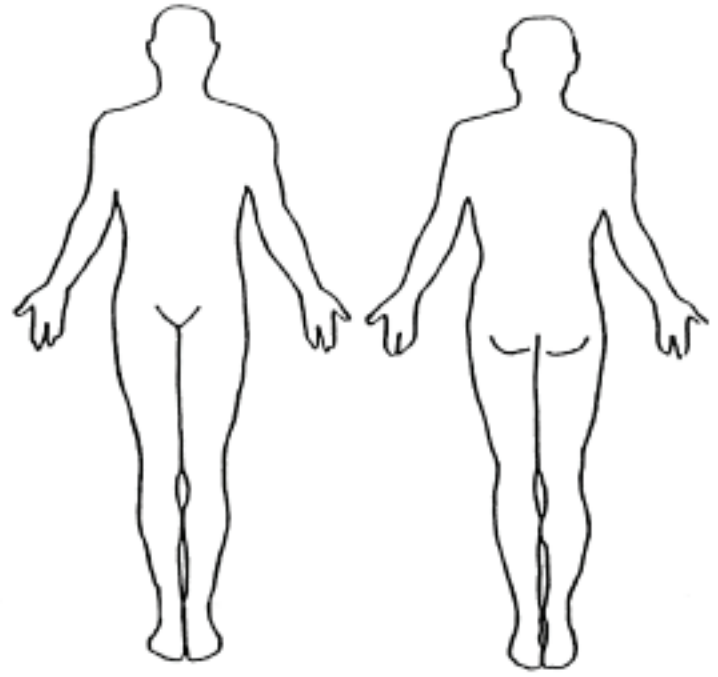
- 1. During the past month, have you been bothered by feeling down, depressed, or hopeless? YES NO
- 2. During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

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:



FRONT

BACK

- 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