Confidential Patient Information Form

Full Name:_____ Date:_____/_____/_____

Date of Birth: _____/_____/_____ Sex: Male / Female Age: _____ Height:_____ Weight: _____

Home Address:_____ City: _____ State: _____ Zip: _____

Phone # : _____ Email: _____

Preferred communication: Email / Phone Call / Text / Mail

Employer Name: _____ Occupation/Work Duties: _____

How or from Who did you hear about our office? _____

FAMILY: Married : Single : Divorced : Widowed

Spouse Name: _____ Spousal Occupation: _____

Children: Name, Ages: _____

Past History of Family Illnesses or Diseases:

Relationship:_____ Illness:_____ Age:____ Living / Deceased
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Chiropractors / Nutritionists you have seen before:

Name: _____ City _____ State _____ When _____
Name: _____ City _____ State _____ When _____
Name: _____ City _____ State _____ When _____

List Medical Doctor seen within past few years:

Name: _____ City _____ State _____ When _____
Name: _____ City _____ State _____ When _____
Name: _____ City _____ State _____ When _____

Date of last physical examination:_____

List all Surgeries / Therapies / Diseases:

Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____

Past Accidents / Injuries / Recurrent Illnesses/ Hospitalizations:

Type: _____ When: _____ Hospitalized? Yes No
Type: _____ When: _____ Hospitalized? Yes No
Type: _____ When: _____ Hospitalized? Yes No

List all Medications / Birth Control/ Pain Relievers / Vitamins / Herbs you are currently taking:

Type: _____ For: _____ How Long: _____
Type: _____ For: _____ How Long: _____
Type: _____ For: _____ How Long: _____
Type: _____ For: _____ How Long: _____
Type: _____ For: _____ How Long: _____
Type: _____ For: _____ How Long: _____
Type: _____ For: _____ How Long: _____

Chiropractic Information Form

Patient Name: _____ Date: _____

Your Health Concern(s) and Complaints:

1. _____ 2. _____
3. _____ 4. _____

Explanation of how Health Concern(s) occurred:

1. _____ 2. _____
3. _____ 4. _____

Health Concern(s) started when: 1. _____ 2. _____ 3. _____ 4. _____

Frequency of Health Concern: Constant / Daily / Weekly / Monthly For How Long: _____

Prior Occurrences: Yes / No How many times: _____ Worse in: A.M. / P.M. / All Day

What makes it better: _____ What makes it worse: _____

What have you tried for the Health Concern: _____

Does Problem Interfere with Work Duties: Yes / No Sleep: Yes / No Daily Routine: Yes / No

History of Trauma to Area: Yes / No When: _____

Other Health Care Providers seen for this problem: _____

Type of Treatment: _____ Results: _____

Sleeping habits: On back On side Side w/ arm extended On stomach

Do You: Sit on Your Wallet: Yes / No Cross Your legs When Sitting: Yes / No

Sit in a Recliner chair with feet up: Yes / No

Frequent Activities/Hobbies: _____

Female: Last date of Menstrual Cycle: _____ Pregnant: NO / YES Due Date: _____

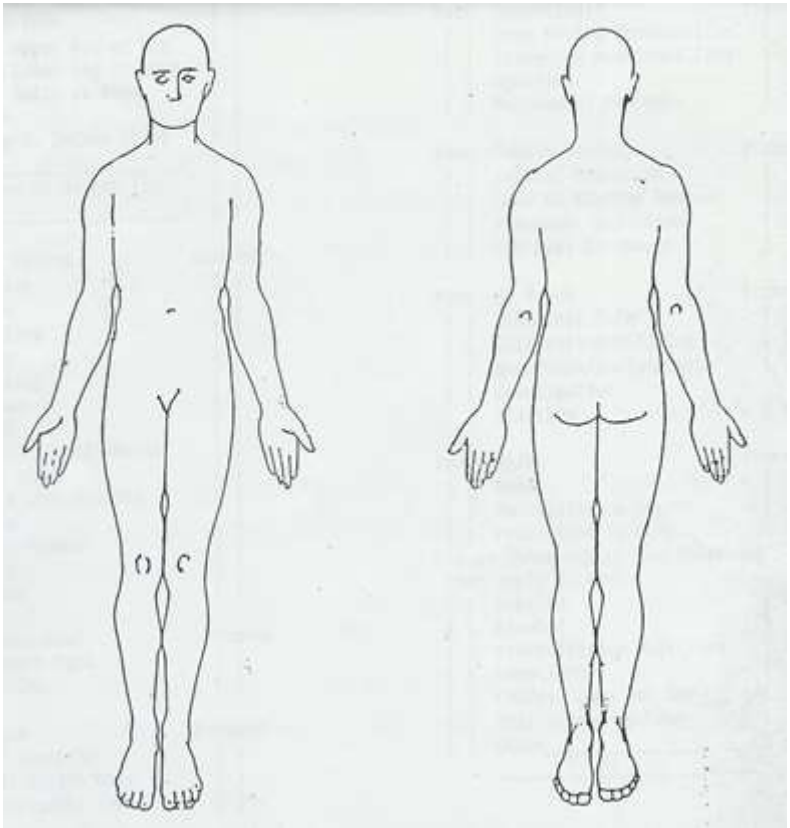
Listed below are common symptoms. If you have ever had a listed symptom in the past or present please check that symptom in the appropriate column.

Past		Present	Past		Present	Past		Present
____	Abnormal Heart Rate	_____	____	Shortness of Breath	_____	_____	Skin Itching	____
____	Swelling	_____	____	Cough	_____	_____	Ulcer	____
____	Poor Circulation	_____	____	Sinus Infections	_____	_____	Heart Attack	____
____	Low Blood Pressure	_____	____	Heartburn	_____	_____	Stroke	____
____	High Blood Pressure	_____	____	Abdominal Pain	_____	_____	Bladder infection	____
____	Low Appetite	_____	____	Diarrhea	_____	_____	Cancer	____
____	High Appetite	_____	____	Constipation	_____	_____	Prostate Troubles	____
____	Weight Loss	_____	____	Skin Rashes	_____	_____	Breast Troubles	____
____	Weight Gain	_____	____	Eczema	_____	_____	HIV / AIDS	____
____	Menstrual Cramps	_____	____	Painful Urination	_____	_____	Depression	____
____	Irregular Menses	_____	____	Loss of Bladder Control	_____	_____	Anxiety	____
____	Menopause Symptoms	_____	____	Frequent Urination	_____	_____	Insomnia	____
____	Bed wetting	_____	____	Dizziness	_____	_____	Ear Noises	____
____	Menopause Symptoms	_____	____	Hand Numbness	_____	_____	Eye Pain	____
____	Ear Pain	_____	____	Feet Numbness	_____	_____	Fatigue	____

PAIN DRAWING

If you are experiencing pain, accurately mark the location and type of pain on the body to the left. Use the appropriate letter(s), to mark all affected areas.

Stabbing (S) **Ache (A)** **Numbness (N)** **Tingling (T)** **Burning (B)**



Please mark on the line the pain level (0-10) that most accurately represents your pain:

Right Now _____ At Best _____ At Worst _____

(Pain Scale)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)