

Confidential Patient Information Sheet

Date ___/___/___

Full Name: _____

Date of Birth: ___/___/___ Age: _____ Height: _____ Weight _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS#: _____ Email: _____

Employer Name: _____ Phone No. (____) _____ Occupation: _____

How did you hear about our office? _____

Whom may we thank for referring you to us? _____

FAMILY: Married___ Single___ Widowed___ Divorced___

Spouse Name: _____

Children (if applicable) with ages: _____

EMERGENCY: (Name of nearest relative or friend not living with you)

Full Name: _____

Home Phone: _____ Work Phone: _____

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

List Medical doctors seen within past year:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

Date of last physical examination: _____

List all surgeries:

Type _____ When: _____

Type _____ When: _____

Type _____ When: _____

Past accidents or injuries:

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

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

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

List Medications and/or Vitamins & Herbs you are taking:

Type: _____ For: _____ How Long: _____

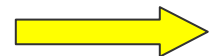
Type: _____ For: _____ How Long: _____

Type: _____ For: _____ How Long: _____

Type: _____ For: _____ How Long: _____

Type: _____ For: _____ How Long: _____

Allergic to: _____



Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you have ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	Musculoskeletal	Present	Past	Respiratory	Present
[]	Neck Pain	[]	[]	Shortness of Breath	[]
[]	Shoulder Pain	[]	[]	Chronic Cough	[]
[]	Pain in Upper Arm or Elbow	[]	[]	Sinus Infection	[]
[]	Hand Pain	[]	Past	Gynecologic	Present
[]	Upper Back Pain	[]	[]	Lumps in Breast	[]
[]	Numbness	[]	[]	Cramps or back aches	[]
[]	Low Back Pain	[]	[]	Irregular Menstrual Flow	[]
[]	Pain in Upper Leg or Hip	[]	[]	Vaginal Discharge	[]
[]	Pain in Lower Leg or Knee	[]	[]	Spotting	[]
[]	Pain in Ankle or Foot	[]	[]	Menopausal Symptoms	[]
[]	Jaw Pain	[]	Past	Genito-Urinary	Present
[]	Swelling in Joints	[]	[]	Painful Urination	[]
[]	List Joints_____		[]	Loss of Bladder Control	[]
[]	Stiffness of Joints	[]	[]	Frequent Urination	[]
[]	List Joints_____		[]	Urethral Discharge	[]
Past	Nervous System	Present	[]	Blood In Urine	[]
[]	Depression	[]	Past	GI Tract	Present
[]	Insomnia	[]	[]	Abdominal Pain	[]
[]	Bed Wetting	[]	[]	Difficult Swallowing	[]
[]	Convulsions	[]	[]	Heartburn/ Indigestion	[]
[]	Dizziness/Fainting	[]	[]	Constipation	[]
[]	Headache	[]	[]	Diarrhea	[]
[]	Muscular Incoordination	[]	[]	Liver Trouble	[]
[]	Hearing Loss	[]	Past	Skin	Present
[]	Tinnitus (Ear Noises)	[]	[]	Rash	[]
[]	Ear Pain	[]	[]	Dermatitis or Eczema	[]
[]	Impaired Vision	[]	[]	Persistent Itching	[]
[]	Eye Pain	[]			
[]	Paralysis	[]			
Past	Cardiovascular	Present			
[]	Rapid Heart Beat	[]			
[]	Slow Heart Beat	[]			
[]	Swelling Ankles	[]			
[]	Poor Circulation	[]			
[]	Low Blood Pressure	[]			
[]	High Blood Pressure	[]			
[]	Chest Pains	[]			
Past	Endocrine	Present			
[]	Loss of Appetite	[]			
[]	Abnormal Weight Gain	[]			
[]	Abnormal Weight Loss	[]			

Please check any of the following that apply to you.

[]	Tobacco # a day_____	[]
[]	Alcohol # a week _____	[]
[]	Tranquilizers/ Sedatives	[]
[]	Laxatives	[]
[]	Coffee, Cups per day_____	[]
[]	Soft Drinks per day_____	[]
[]	Other_____	[]

How many Hours of sleep a day _____

Number of glasses of water a day _____

On a scale 1-10 what level stress do you experience daily? _____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Past	Condition	Present	Past	Condition	Present
[]	Hemorrhoids	[]	[]	Emphysema	[]
[]	Rheumatic Heart Disease	[]	[]	Arthritis	[]
[]	Asthma	[]	[]	Drug or Alcohol Dependency	[]
[]	Angina	[]	[]	Diabetes	[]
[]	Heart Attack	[]	[]	Ulcer	[]
[]	Stroke	[]	[]	Kidney Stones	[]
[]	Bladder Infection	[]	[]	Kidney Infection	[]
[]	Gall Bladder	[]	[]	Cancer	[]
[]	Prostate Troubles	[]			
[]	HIV Positive/AIDS	[]	[]	Other_____	[]