

**PATIENT INTRODUCTION Today’s Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  **M** [ ]  **F**  **Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_

**Cell #**: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]  single** **[ ]  married** **[ ]  separated** **[ ]  divorced** **[ ]  widowed**

**SPOUSES NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHOM MAY WE THANK FOR REFERRING YOU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **[ ]  Not Employed** **[ ]  Part-Time Student** **[ ]  Full-Time Student** **[ ]  Retired**

**Briefly describe the reason for your visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU HAVE A HISTORY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK ALL THAT APPLY**

**[ ]  Neck Pain** **[ ]  Pacemaker** **[ ]  Psychiatric**

**[ ]  Low Back Pain** **[ ]  Arthritic Disease** **[ ]  Arm/Leg Numbness**

**[ ]  Osteoporosis** **[ ]  Vertigo/Dizziness** **[ ]  Diabetes**

**[ ]  Surgery** **[ ]  Sports Injury** **[ ]  Autoimmune Disease**

**[ ]  Headaches** **[ ]  Disc Bulge** **[ ]  Sciatica**

**[ ]  Recent Weight Loss** **[ ]  Medication** **[ ]  Spinal Fusion**

**[ ]  Cancer** **[ ]  Kidney Stones** **[ ]  Major Trauma**

**[ ]  Stroke** **[ ]  Scoliosis** **[ ]  Cardiovascular**

**[ ]  Recent Weight Gain** **[ ]  Genitourinary** **[ ]  Asthma**

**[ ]  Skin Disease** **[ ]  ADD/ADHD** **[ ]  Respiratory Disease**

**[ ]  GI Disease** **[ ]  Ear Infections** **[ ]  Breast Augmentation**

**[ ]  Allergies** **[ ]  Auto Accident** **[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you pregnant?** **[ ]  NO** **[ ]  YES, my due date is: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Have you ever been treated by a chiropractor before?** **[ ]  NO** **[ ]  YES, with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this condition due to an accident? [ ]  NO [ ]  Yes, Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Type: [ ]  Auto [ ]  Work [ ]  Home**

**To whom have you made a report of your accident? [ ]  Auto Insurance [ ]  Employer [ ]  Worker Comp [ ]  Other**

**Do you have health insurance? [ ]  No [ ]  Yes, what company? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of an emergency, whom shall we contact?**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

When did the symptoms **BEGIN**? [ ]  GRADUAL [ ]  SUDDEN [ ]  ACCIDENT [ ]  AUTO [ ]  WORK [ ]  UNKNOWN

**How Long** have you had your **SYMPTOMS**? [ ]  PAST FEW DAYS [ ]  PAST WEEK OR SO [ ]  PAST MONTH

[ ]  PAST FEW MONTHS [ ]  PAST YEAR [ ]  PAST FEW YEARS [ ]  PAST YEARS+

Are your **SYMPTOMS**? [ ]  GETTING WORSE [ ]  GETTING BETTER [ ]  NO CHANGE

**How bad does it hurt?** Please circle one (**NO PAIN**) 0 1 2 3 4 5 6 7 8 9 10 (**WORST PAIN** **IMAGINABLE**)

 BACK

FRONT

Pain is **WORSE** IN THE:

[ ]  MORNING [ ]  EVENING [ ]  AFTERNOON [ ]  THROUGHOUT THE NIGHT

**MADE WORSE WHEN:**

[ ]  BENDING/TWISTING [ ]  CARRYING [ ]  COUGHING

[ ]  DRIVING [ ]  EXERCISING [ ]  KNEELING [ ]  LIFTING

[ ]  LYING/SLEEPING [ ]  STANDING [ ]  WALKING

[ ]  WORKING [ ]  SITTING [ ]  OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain is **BEST** IN THE:

[ ]  MORNING [ ]  EVENING [ ]  AFTERNOON [ ]  THROUGHOUT THE NIGHT

**MADE BETTER WHEN:**

L

R

R

L

[ ]  NOTHING [ ]  MEDICATION [ ]  EXERCISE

[ ]  HEAT [ ]  ICE [ ]  MASSAGE [ ]  MOVEMENT

[ ]  REST [ ]  STRETCHING [ ]  STANDING

[ ]  SITTING

PLEASE MARK WHERE YOUR PAIN IS LOCATED AND RADIATES TO

**DESCRIPTION** of your pain or symptoms:

[ ]  ACHING [ ]  PINCHING [ ]  BURNING [ ]  NUMBNESS

[ ]  SWELLING [ ]  DEEP [ ]  SHARP

[ ]  CRAMPING [ ]  SHOOTING [ ]  DULL

[ ]  THROBBING [ ]  STIFFNESS [ ]  TINGLING

[ ]  RADIATING [ ]  TIGHTNESS

**FREQUENCY:**

[ ]  RARELY (1%-10%) [ ]  OCCASIONAL (11%-25%) [ ]  INTERMITTENT (26%-50%)

[ ]  FREQUENT (51%-75%) [ ]  PERSISTENT (76%-99%) [ ]  CONSTANT (100%)

**YOUR CHIEF COMPLAINT IS:** [ ]  MILDLY [ ]  SLIGHTLY [ ]  MODERATELY [ ]  SEVERELY **affected by doing the following:**

[ ]  SITTING [ ]  BATHING [ ]  USING STAIRS [ ]  STANDING [ ]  TOILET USE

[ ]  LAUNDRY [ ]  GROOMING [ ]  IN/OUT OF BED [ ]  HOUSEKEEPING [ ]  DRESSING

[ ]  IN/OUT OF CAR [ ]  SHOPPING [ ]  EATING [ ]  MEAL PREP [ ]  USING PHONE

[ ]  WORKING [ ]  SLEEPING

**PREVIOUS CARE FOR YOUR CURRENT COMPLAINT:**

[ ]  CHIROPRACTIC [ ]  MASSAGE [ ]  MEDICAL DOCTOR [ ] E.R [ ]  ORTHOPEDIST [ ]  NEUROLOGIST [ ]  FAMILY DOCTOR

[ ]  PHYS. THERAPY [ ]  ACUPUNCTURE [ ]  BED REST [ ]  MRI [ ]  CT SCAN [ ]  SURGERY [ ]  RX. PAIN KILLERS

[ ]  OTC PAIN MEDS [ ]  COLD PACKS [ ]  HOT PACKS [ ]  SPINAL SURGERY [ ]  SPINAL FUSION [ ]  INJECTIONS

[ ]  MUSCLE RELAXANTS

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_