A logo with a brain

Description automatically generated

**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: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ A logo with a brain

Description automatically generated

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

A person standing next to another person

Description automatically generatedPain 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_