

**Section 1: Patient Information**

Today's Date: \_\_\_/\_\_\_/\_\_\_

Name (first, middle, last): \_\_\_\_\_

Preferred Name: \_\_\_\_\_  Male  Female Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

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

Phone Number: Cell (\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

SSN (last 4): \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widow Women Only: Are you Pregnant?  Yes  No

Spouse (Parent if patient is under 18) \_\_\_\_\_ Date of Birth of Spouse (Parent if patient is under 18) \_\_\_/\_\_\_/\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**Section 2: Current Health Condition**

Primary Complaint: \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Has it ever occurred before?  Yes  No

Was it due to an accident?  Yes  No

If yes, what type?  Auto  Work  Personal

Rate the severity of your pain on a scale of  
 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Have you seen any other doctors for this?  Yes  No

If yes, please list doctors name and treatment if any \_\_\_\_\_

Is this pain?  Occasional (1-33%)  Intermittent (34-66%)  
 Frequent (67-99%)  Constant (100%)

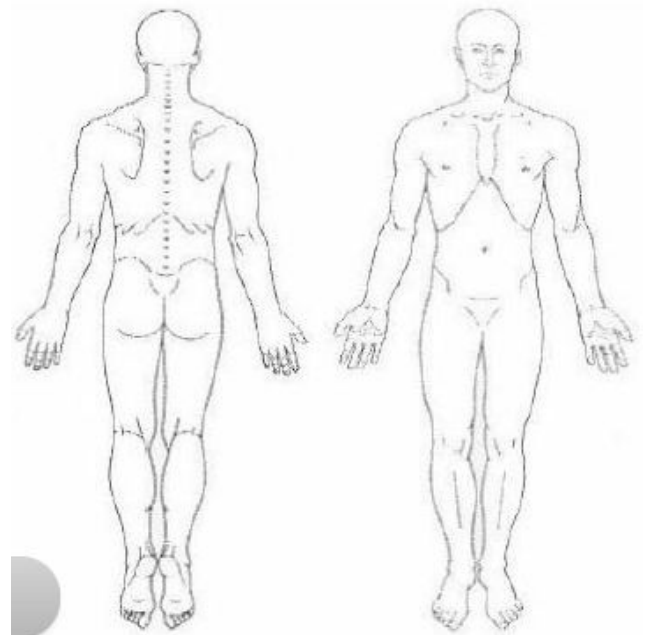
Is this condition getting  Better  Worse or is it  
 staying the  Same?

Is this condition worse in the  AM  PM or  Same?

Second Complaint: \_\_\_\_\_

Third Complaint: \_\_\_\_\_

**Please mark** the areas on the **Diagram** with the following **letters** to describe your symptoms:  
**A=A**ching **B=B**urning **D=D**ull **N=N**umbness  
**R=R**adiating **S=S**harp/**S**tabbing **T=T**ingling



Patient/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

## Section 3: Functional Assessment

Please **Circle One** answer that best indicates the impact of your current condition on your ability to perform each of the following activities. If the activity does not pertain to you, please place an 'X' in the column marked "N/A".

\* "Normal" is what you are accustomed to on a daily basis.

**0**=Normal Function   **1**=Minimally Difficult   **2**=Moderately Difficult   **3**=Very Difficult   **4**=Unable to Perform

ACTIVITY	SCORE					N/A
Sleep Normally	0	1	2	3	4	
Grooming	0	1	2	3	4	
Getting dressed	0	1	2	3	4	
Food prep / Cooking / Eating	0	1	2	3	4	
Sitting for a normal* amount of time	0	1	2	3	4	
Standing for a normal* amount of time	0	1	2	3	4	
Walking	0	1	2	3	4	
Running / Jogging	0	1	2	3	4	
Going up and down stairs	0	1	2	3	4	
Recreational / Sports activities	0	1	2	3	4	
Reaching above the head or across the body	0	1	2	3	4	
Squatting down to pick up an item	0	1	2	3	4	
Lifting / Carrying up to 10 lbs.	0	1	2	3	4	
Getting up / down from chair to bed and bed to chair	0	1	2	3	4	
Driving	0	1	2	3	4	
Performing all job requirements at work	0	1	2	3	4	

Patient/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section 4: Medical History**

Using the codes below, please fill in **EVERY** blank with the applicable letter.

**C = Current Health Condition**      **P = Past Health Condition**      **N = Never had this Health Condition**

- |                        |                        |                         |                       |
|------------------------|------------------------|-------------------------|-----------------------|
| ___ AIDS/HIV           | ___ Chemical Depend.   | ___ Hernia              | ___ Parkinson's       |
| ___ Alcoholism         | ___ Chest Pain         | ___ Herniated Disk      | ___ Pinched Nerve     |
| ___ Allergies          | ___ COPD               | ___ High Blood Pressure | ___ Pneumonia         |
| ___ Anemia             | ___ Diabetes           | ___ Kidney Disease      | ___ Prostate Problems |
| ___ Anxiety/Depression | ___ Digestion Problems | ___ Liver Disease       | ___ Psychiatric Care  |
| ___ Appendicitis       | ___ Dizziness/Vertigo  | ___ Menstrual Problems  | ___ Skin Problems     |
| ___ Arthritis          | ___ Eating Disorder    | ___ Migraines           | ___ Sleeping Problems |
| ___ Asthma             | ___ Emphysema          | ___ Mononucleosis       | ___ STD               |
| ___ Autoimmune Dis.    | ___ Epilepsy/Seizures  | ___ Multiple Sclerosis  | ___ Stroke            |
| ___ Back Pain          | ___ Fatigue            | ___ Neck Pain           | ___ Thyroid Disease   |
| ___ Bleeding Disorder  | ___ Headaches          | ___ Numbness/Tingling   | ___ Tumors/Growths    |
| ___ Bronchitis         | ___ Heart Disease      | ___ Osteoporosis        | ___ Ulcers            |
| ___ Cancer             | ___ Hepatitis          | ___ Pacemaker           |                       |

Please list any other complaints / conditions you currently have or have had in the past \_\_\_\_\_

Please list all broken bones / injuries / surgeries you have had and the date they occurred \_\_\_\_\_

Is there anything else the doctor should know?  Yes  No If yes, please describe \_\_\_\_\_

**Section 5: Family History**

Does anyone in your family suffer from the same condition(s) or other chronic illnesses?  Yes  No

If yes, whom and what condition(s) \_\_\_\_\_

Section 6: Medications	Vitamins/Supplements	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Section 7: Chiropractic History

Have you ever seen a Chiropractor before?  Yes  No Date of most recent visit \_\_\_\_\_

For what reason were you seen? \_\_\_\_\_ Were you helped?  Yes  No

### Section 8: Goals For Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible. Thank you.

- I want the Doctor to select the type of care appropriate for my condition(s).
- Relief Care: Symptomatic relief of pain or discomfort
- Corrective Care: Correcting and relieving the cause of the problem as well as the symptom(s).

### Section 9: Our Commitment to You

We are committed to giving you the best care possible in our office. If there is ever anything you wish to talk to the doctor about whether it be a question, concern or how we may better help you, please let one of us know. We are here to serve you and we are grateful for the opportunity.

### Section 10: Preferred Contact Number and Time

Please indicate your preferred contact number and time of day. Thank you.

Preferred Contact Number: \_\_\_\_\_

Preferred Time: \_\_\_\_\_

Patient/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_