PATIENT HISTORY

NAME: _____ DATE: _____

PRESENT MEDICAL HISTORY:

What can we help you with?_____
_____

How long have you had this problem? _____
Have you had any previous care or seen any other provider(s) for this problem? _____
_____

What are you doing for it now? _____
Is it working? _____

Have you noticed any changes in your daily activities due to the problem or pain (ie dressing, cooking, etc.)?_____

Are there any other related or unrelated symptoms?_____
_____

What is your overall stress level?

LOW 0 1 2 3 4 5 6 7 8 9 10 HIGH

What is your sleeping habit? on BACK on SIDE on STOMACH

When was the last time you really felt good? _____

FAMILY HISTORY

Mother:	alive	health problems:	_____
	deceased	Age: _____	cause of death: _____
Father:	alive	health problems:	_____
	deceased	Age: _____	cause of death: _____

PAST MEDICAL HISTORY

What medications are you taking? _____
What supplements are you taking? _____
What other doctors are you seeing for any reason (including pregnancy)? _____
_____

Have you ever had any serious falls, accidents, strains, hospitalizations, surgeries, length illnesses? Yes / No
If yes, please describe. _____
_____

Patient signature: _____ date: _____

PATIENT HISTORY / REVIEW OF SYSTEMS

Name: _____ Date: _____

Please tell us if YOU or a member of YOUR IMMEDIATE FAMILY have had any of the following.

	Individual		**Family Member**	
Back pain / Leg pain	Yes	No	Yes	No
Neck Pain / Arm Pain	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Neurological Disease / Headaches / Seizures	Yes	No	Yes	No
Heart / Circulatory Problems	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Stomach or Bowel Problems	Yes	No	Yes	No
Broken Bones	Yes	No	Yes	No
Skin Disease	Yes	No	Yes	No
Prostate Disease / Hormone Therapy	Yes	No	Yes	No
Depression, Anxiety, etc.	Yes	No	Yes	No
Painful or Irregular Menstrual Cycles	Yes	No	Yes	No
Tendonitis	Yes	No	Yes	No
Exercise on a regular basis	Yes	No	Yes	No
Motor Vehicle Accident or Other Injuries	Yes	No	Yes	No
Alcohol / Nicotine	Yes	No	Yes	No
Nicotine	Yes	No	Yes	No
Allergies/Upper respiratory infection/flu/cough	Yes	No	Yes	No
Surgeries	Yes	No	Yes	No
Chiropractic Treatment Before	Yes	No	Yes	No
Unintended weight gain / loss	Yes	No	Yes	No
Recent international travel	Yes	No	Yes	No

Please explain any “Yes” answers above:

_____

_____

_____

PATIENT DATA SHEET

PERSONAL INFORMATION DATE: _____

PATIENT NAME: _____
First Middle Initial Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____)_____ WORK / CELL PHONE: (_____)_____

SOC SEC #: _____ DATE OF BIRTH: _____ GENDER: _____

MARITAL STATUS: S M D W EMPLOYER: _____

OCCUPATION: _____ REFERRED BY: _____

EMERGENCY CONTACT NAME : _____ RELATIONSHIP: _____

PHONE #: _____

EMAIL ADDRESS: _____

RESPONSIBLE PARTY INFORMATION / NAME OF INSURED

NAME: _____
First Middle Initial Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____)_____ ALTERNATE PHONE: (_____)_____

SOC SEC #: _____ DATE OF BIRTH: _____ GENDER: _____

EMPLOYER: _____ OCCUPATION: _____

CONSENT TO TREAT

I hereby authorize consent for _____ (clinic/doctor), to provide medical care and treatment.

PRINT: _____ SIGN: _____DATE: _____
Patient Patient

PRINT: _____ SIGN: _____DATE: _____
Patient or Legal Guardian Patient or Legal Guardian

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorized and request my insurance company to pay directly to _____(clinic), insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents.

PRINT: _____ SIGN: _____DATE: _____
Patient Patient

PRINT: _____ SIGN: _____DATE: _____
Patient or Legal Guardian Patient or Legal Guardian

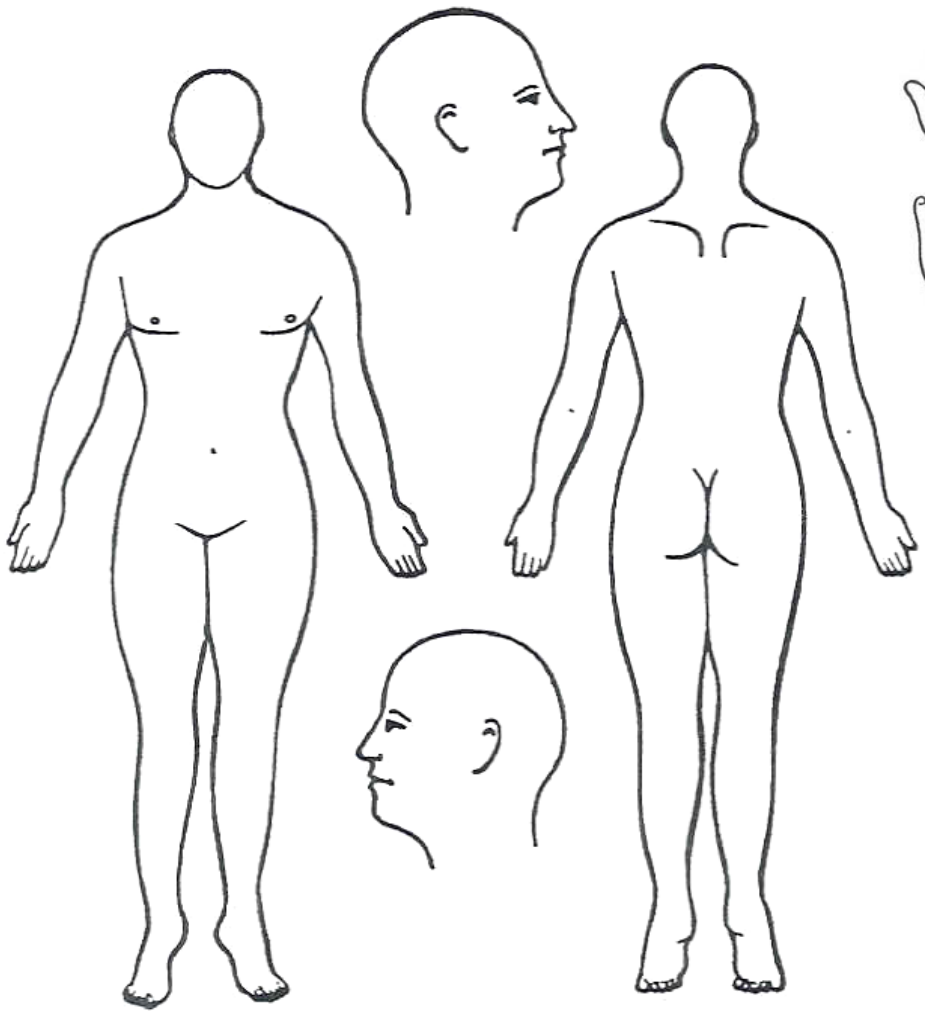
Pain Drawing

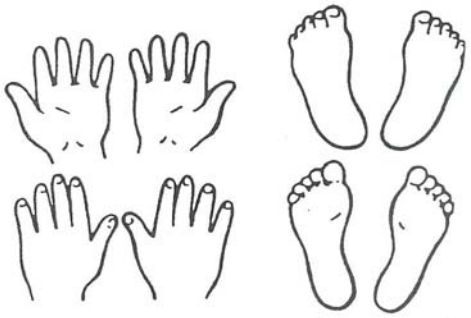
Name: _____ Date: _____

Tell us where you hurt.

Please read carefully:
Mark the areas on your body where you feel you rpain. Include all affected areas. Mark areas of pain radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache	> > > >	Numbness	= = = =	Pins and Needles	◯◯◯◯
Burning	x x x x	Stabbing	/ / / /	Throbbing	~ ~ ~ ~





Severity of Pain

List the region of pain.
Circle the severity number.
1=least pain, 10=greatest pain

ex: _____NECK_____
0 1 2 3 4 5 6 7 8 9 10

1. _____
0 1 2 3 4 5 6 7 8 9 10

2. _____
0 1 2 3 4 5 6 7 8 9 10

3. _____
0 1 2 3 4 5 6 7 8 9 10

4. _____
0 1 2 3 4 5 6 7 8 9 10

5. _____
0 1 2 3 4 5 6 7 8 9 10