Last Name _____ First Name _____ Middle Initial ___

Date of Birth_____ Age_____ Gender: ❑M ❑F Social Security #_____-_____-_____

Race_____Ethnicity_____ (Medicare requires these questions on form)

Preferred Language _____ Email_____

Address_____ City/State/Zip _____

Phone (Home) _____ (Cell)_____ (Work)_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Spouse's Name _____

Emergency Contact Name _____ Emergency Phone _____

Your Occupation _____ Employer _____

Employer Address _____ Job Duties_____

Would you like us to verify your insurance? ❑Y ❑N Insurance Company_____

Group Number: _____ Policy Number: _____

How did you hear about us or who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

What is your main complaint or symptom? _____

- Date when symptom first appeared: _____ Is this a ❑ work or ❑ auto accident injury?
- Describe how your symptom(s) happened: _____
- Did your complaint begin: ❑ Gradually ❑ Suddenly
- Since onset, have your complaints: ❑Worsened ❑ Improved ❑ Stayed The Same
- Type of Pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Burn ❑ Throb
- What makes the symptoms worse? _____
- What makes the symptoms better? _____
- Does the Pain Radiate into your: ❑ Arm ❑ Leg ❑ Other_____ ❑ Does not radiate
- Do you experience Numbness or Tingling? ❑ Yes ❑ No If so, where? _____
- How often do you experience these symptoms? ❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 10%
- PAIN INTENSITY: **Use the key below to rate the severity of your complaints by circling or marking the appropriate number below.**

  1. Right now, what is the intensity of your pain on a scale of 0-10?
     0 1 2 3 4 5 6 7 8 9 10
  2. What is the intensity of your pain at its least on a scale of 0-10?
     0 1 2 3 4 5 6 7 8 9 10
  3. What is the intensity of your pain at its worst on a scale of 0-10?
     0 1 2 3 4 5 6 7 8 9 10

  KEY
  0 = No Pain, Normal
  1 = Minimal, Hardly Noticed
  2 = Very Mild
  3 = Mild, Tolerable Pain
  4 = Mild to Moderate Pain
  5 = Moderate Pain, Distressing
  6 = Moderately Severe / Intense
  7 = Very Intense, Limits Most Activities
  8 = Horrible Pain, Limits All Activities
  9 = Very Severe, Unbearable Pain
  10 = Excruciating, Unimaginable Pain

- What is the pain interfering with that is important in your life? _____
- Have you ever been to another doctor for this problem? ❑ Y ❑ N Who? _____
- List any previous tests and or treatments you have had for this condition: _____

  _____
- Have you experienced this symptom before? ❑ Y ❑ N If yes, when and describe: _____

  _____

What is your second or other main complaint(s) or symptom(s)? _____

_____

- Date when symptom first appeared: _____ Is this a ❑ work or ❑ auto accident injury?
- Describe how your symptom(s) happened: _____
- Did your complaint begin: ❑ Gradually ❑ Suddenly
- Since onset, have your complaints: ❑ Worsened ❑ Improved ❑ Stayed The Same
- Type of Pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Burn ❑ Throb
- What makes the symptoms worse? _____
- What makes the symptoms better? _____
- Does the Pain Radiate into your: ❑ Arm ❑ Leg ❑ Other_____ ❑ Does not radiate
- Do you experience Numbness or Tingling? ❑ Yes ❑ No If so, where? _____
- How often do you experience these symptoms? ❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 10%
- PAIN INTENSITY: **Use the key below to rate the severity of your complaints by circling or marking the appropriate number below.**

  1. Right now, what is the intensity of your pain on a scale of 0-10?
     0 1 2 3 4 5 6 7 8 9 10
  2. What is the intensity of your pain at its least on a scale of 0-10?
     0 1 2 3 4 5 6 7 8 9 10
  3. What is the intensity of your pain at its worst on a scale of 0-10?
     0 1 2 3 4 5 6 7 8 9 10

KEY

0 = No Pain, Normal
1 = Minimal, Hardly Noticed
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7 = Very Intense, Limits Most Activities
8 = Horrible Pain, Limits All Activities
9 = Very Severe, Unbearable Pain
10 = Excruciating, Unimaginable Pain

- What is the pain interfering with that is important in your life? _____
- Have you ever been to another doctor for this problem? ❑ Y ❑ N Who? _____
- List any previous tests and or treatments you have had for this condition: _____

_____

- Have you experienced this symptom before? ❑ Y ❑ N If yes, when and describe: _____

_____

Do you have other complaints that you want the Doctor to evaluate? ❑ Y ❑ N If yes, describe: _____

_____

Have you ever been to a Doctor of Chiropractic before? ❑Y ❑N If yes, Dr. name _____
Approximate date of last visit:_____ Reason for care: _____

Do you see a medical doctor for general care/checkups? ❑Y ❑N If yes, Dr. name: _____
Address:_____ City/State/Zip:_____

Approximate date of last visit:_____ Reason for visit:_____

Please list all past hospitalizations and surgeries:

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____

Please list any significant past accidents and falls: (auto accident, slip and falls, sports or work injury)

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

Please list any medications or vitamins you are currently taking: _____
_____
_____
_____

Please list known allergies to medications or foods: _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

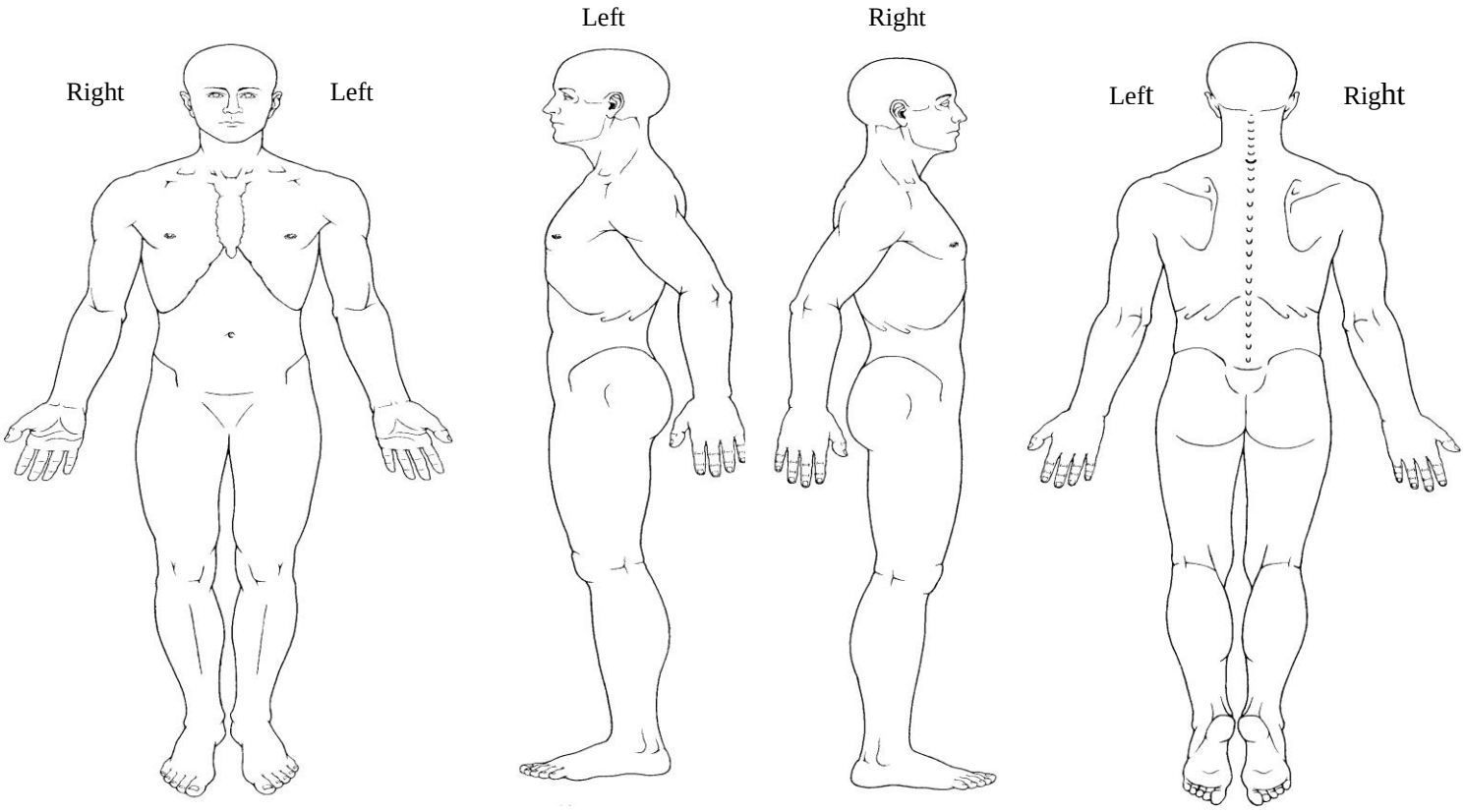
PREVIOUSLY	CURRENTLY		PREVIOUSLY	CURRENTLY		PREVIOUSLY	CURRENTLY	
( )	( )	DIABETES	( )	( )	HIGH BLOOD PRESSURE	( )	( )	ULCERS
( )	( )	LOW BLOOD SUGAR	( )	( )	LOW BLOOD PRESSURE	( )	( )	DRY SKIN
( )	( )	RINGING IN THE EARS	( )	( )	HEART DISEASE	( )	( )	STROKE
( )	( )	SKIN RASHES	( )	( )	HEMORRHOIDS	( )	( )	ASTHMA
( )	( )	CONSTIPATION	( )	( )	COLD HANDS / FEET	( )	( )	FATIGUE
( )	( )	HEARTBURN	( )	( )	SINUS CONGESTION	( )	( )	CANCER
( )	( )	NERVOUSNESS	( )	( )	DEPRESSION	( )	( )	SCOLIOSIS
( )	( )	HIGH CHOLESTEROL	( )	( )	POOR DIGESTION/GAS	( )	( )	ARTHRITIS
( )	( )	HIATEL HERNIA	( )	( )	YEAST INFECTIONS	( )	( )	ANEURYSM
( )	( )	INGUINAL HERNIA	( )	( )	HEPATITIS A B C	( )	( )	LIVER DISEASE
( )	( )	TUBERCULOSIS	( )	( )	HEADACHES	( )	( )	OSTEOPOROSIS
( )	( )	H I V OR AIDS	( )	( )	IRRITABLE BOWEL	( )	( )	FIBROMYALGIA

Do you have or have you had any disease or medical problems not listed? ❑Y ❑N If yes, explain:_____
_____

Vascular Risk Evaluation / Social History:

*****Have you ever suffered a stroke? ❑Y ❑N *****Anyone in your family had a stroke? ❑Y ❑N
Who / Age _____
*****Have you ever had a heart attack? ❑Y ❑N *****Anyone in your family had a heart attack? ❑Y ❑N
Who / Age _____
*****Do you have high blood pressure? ❑Y ❑N *****Anyone in your family have high blood pressure? ❑Y ❑N
Who / Age _____
Do you smoke? ❑Y ❑N If yes, how much?_____ How long? _____
Have you ever smoked in the past? ❑Y ❑N When did you quit? _____
Do you drink alcohol? ❑Y ❑N If yes, how much? _____
Do you take birth control pills? ❑Y ❑N Have you ever taken birth control pills? ❑Y ❑N
Do you exercise? ❑Y ❑N If yes, list frequency & intensity:_____
What do you enjoy doing most when you're not working? _____
_____
Is there any additional information you would like the doctor to know about before beginning your care? ____
_____
Please mark areas of interest if you desire more information: ❑Nutrition / Supplements ❑Massage
❑Wellness Care ❑Body Purification ❑Decompression ❑Other ❑Laser Therapy

PAIN LOCATION



Please use the following symbols on the pain diagram
to accurately describe the location and symptom of your condition.

P P P	Where you experience Pain
S S S	Where you experience Spasms
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramping

Please circle or mark your answers:

- In general, how would you rate your overall health? Poor = 0 1 2 3 4 5 6 7 8 9 10 = Excellent
- How valuable is your health to you? No value = 0 1 2 3 4 5 6 7 8 9 10 = Extremely Valuable

PATIENT SIGNATURE _____ DATE_____