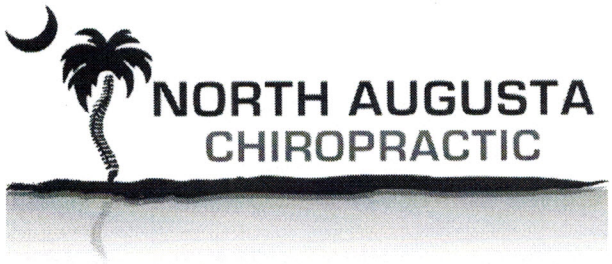


Patient Information Form

Date: ___ / ___ /_____	Name: _____ First Last MI	SS#: _____ - _____ - _____

Home Phone:	Cell Phone:	Sex: Male / Female	Age: _____	Birth Date: ____ / ____ /____
Address:	City/State:			Zip Code:
Email:				Are you Pregnant? YES / NO
Occupation:	How were you referred to our office?			

___ Married ___ Separated ___ Divorced ___Widowed ___ Single ___ Minor	Spouse or Parent Name:
Spouse Occupation:	Names & Ages of Children:

Emergency Contact:	Relationship to Patient:	Contact Phone Number:

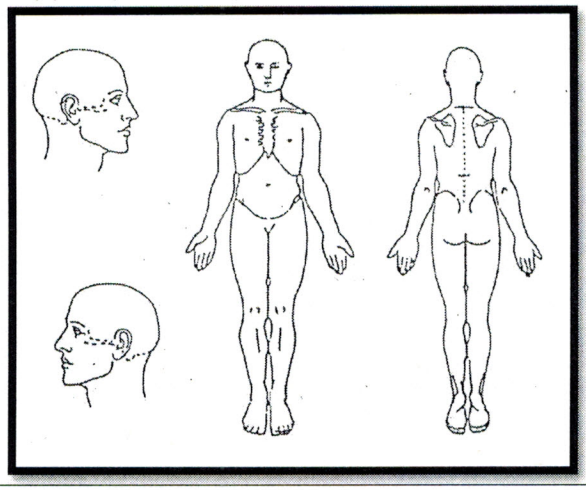
Patient Condition:

Reason for your visit:	When did your symptoms begin?

Has your health problem been: ___ Improving ___ Worsening ___ Staying the Same	Rate the severity on a scale of 1 (least pain) to 10 (severe pain): 1 2 3 4 5 6 7 8 9 10

Type of Pain: ___ Sharp ___ Dull ___Throbbing ___ Numb ___ Achy ___ Burning ___Shooting ___Stiff ___ Other	How often do you have this pain? ___ Daily ___ Weekly ___ Monthly ___ Other	Is it constant or does it come and go? ___ Constant ___ Comes and Goes

Please Circle the exact location of any pain you are experiencing:



Does this condition interfere with your (mark all that apply):

___ Home Activities ___ Rest ___ Work Activities ___ Recreational Activities

Please Describe:

Please list all medications currently taking. (Include prescription and non-prescription drugs).

Please list all known allergies:

Smoker: YES / NO How Long: _____ Number of packs per day: _____	Alcohol: YES / NO Number of Drinks per day: _____ Number of Drinks per week: _____	Other Drug Use:	Exercise: YES / NO Daily / Weekly / Monthly Type: _____

Review of Systems

Constitutional	No	Yes
Excessive thirst	☐	☐
Chills	☐	☐
Convulsions	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Weight loss	☐	☐
Loss of sleep	☐	☐
Night sweats	☐	☐
Psychiatric		
Nervousness	☐	☐
Depression	☐	☐
Mood swings	☐	☐
Musculoskeletal		
Arthritis	☐	☐
Bursitis	☐	☐
Foot trouble	☐	☐
Hernia	☐	☐
Neck pain	☐	☐
Mid back pain	☐	☐
Low back pain	☐	☐
Fractures	☐	☐
Cardiovascular		
Hardening of arteries	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Chest pain	☐	☐
Poor circulation	☐	☐
Rapid heartbeat	☐	☐
Slow heartbeat	☐	☐
Swelling of ankles	☐	☐

Respiratory	No	Yes
Chest pain	☐	☐
Chronic cough	☐	☐
Difficulty breathing	☐	☐
Spitting up blood	☐	☐
Spitting up phlegm	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Gastrointestinal		
Excessive belching	☐	☐
Excessive gas	☐	☐
Colitis	☐	☐
Colon trouble	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Difficult digestion	☐	☐
Bloated abdomen	☐	☐
Excessive hunger	☐	☐
Gallbladder trouble	☐	☐
Hemorrhoids	☐	☐
Intestinal worms	☐	☐
Jaundice	☐	☐
Liver trouble	☐	☐
Nausea	☐	☐
Stomach pain	☐	☐
Poor appetite	☐	☐
Vomiting	☐	☐
Vomiting of blood	☐	☐
Skin		
Bruise easily	☐	☐
Dryness	☐	☐
Hives/allergy	☐	☐
Itching	☐	☐
Varicose veins	☐	☐

Eye	No	Yes
Eye pain	☐	☐
Failing vision	☐	☐
Far sighted	☐	☐
Near sighted	☐	☐
Glaucoma	☐	☐
Blurred vision	☐	☐
Ears, Nose, and Throat		
Ringing in ears	☐	☐
Colds	☐	☐
Deafness	☐	☐
Earaches	☐	☐
Ear discharge	☐	☐
Ear noise	☐	☐
Enlarged glands	☐	☐
Enlarged thyroid	☐	☐
Gum trouble	☐	☐
Hay fever	☐	☐
Hoarseness	☐	☐
Nasal obstruction	☐	☐
Nose bleeds	☐	☐
Sinus infections	☐	☐
Sore throat	☐	☐
Genitourinary		
Blood in urine	☐	☐
Frequent urination	☐	☐
Kidney infection	☐	☐
Painful urination	☐	☐
Prostate trouble	☐	☐
Seizures	☐	☐
Are you pregnant?	☐	☐
Neurological		
Tremors	☐	☐
Fainting spells	☐	☐
Coordination difficulty	☐	☐

Family History

Please mark relative's current age or age at time of death. Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy - Asthma	Alcohol abuse	Arthritis - Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (describe)	
Father																			
Mother																			
Siblings																			

Past Medical History:

Have you ever received Chiropractic care? YES / NO	If yes, please list the doctor's name and location of the office:
May we have your permission to update your medical doctor regarding your care at this office: YES / NO	Family Medical Doctor (Name and Location):

Surgeries:

YEAR	BODY REGION	PROCEDURE

Prior Accidents / Work Injuries:

YEAR	BODY REGION	TYPE OF TREATMENT

Medical Illness:

List current and past illnesses not mentioned above:

I understand that if any changes are made to my personal or insurance information while being treated, it is my responsibility to inform the facility of said changes in a timely manner.

X_____ **Date:**_____

Patient / Responsible Party Signature