



CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		SSN:		Date:	
Address:					
Street		City		State Zip	
Home phone:			Work phone:		
Cell phone:			Email address:		
Best time/place to contact you:					
Date of birth:			Age:		
No. of children:			Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Height:			Weight:		
What do you prefer to be called?					
Marital status: M S W D			Spouse/guardian name:		
Occupation:					
Employer's name & address:					
Primary Care Physician's name & phone number:					
Name of person responsible for account:					

Who may we thank for referring you? _____

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

If you have pain, is it dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition? _____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this, as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? Please list all injuries from childhood to present. (ie: falls out of a tree, off trampoline, off roof, down stairs, skiing, sledding, falls from a horse, monkey bars, slide, snowmobile, motorcycle, mini-bike, sports injuries or concussions, etc.)

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Do you have problems falling asleep? Yes No

Do you have problems staying asleep? Yes No

Do you wake because you have to urinate? Yes No How many times per night? _____

Do you have digestive problems: (circle all that apply)

Constipation, diarrhea, irritable bowel syndrome, Crohn's, colitis, heartburn, indigestion, gas, bloating, belching, problems with greasy foods

Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **X** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had in the past or have now (mark a “-“for have had and a “x” for have now):

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eczema | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Gas, bloating, belching | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV (Aids) | <input type="checkbox"/> Irregular Periods |
| <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Malaria | <input type="checkbox"/> Measles | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> OTHER |

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

- 1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____

- 2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____

- 3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10 (1 is very little stress at all) please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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What are the 3 most important things in your life?

- 1. _____
- 2. _____
- 3. _____

What things do you want to do again that are limited by your health right now?

- 1. _____
- 2. _____
- 3. _____

Is there anything else which may help to better understand you, which has not been discussed?

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____