Patient Contact

Title: Mr./Mrs./Ms./Dr./Rev./Rank____

Last Name __________________________First Name ____________________________M.I.__________

Address __________________________City _______________ State _______Zip_____________________

Home Phone __________________________________ Cell Phone _________________________________

Work Phone ___________________________ E-Mail ____

Patient Personal

Age_________ Date of Birth____________ Gender: Male Female

Social Security #__________________________ Drivers License #/State ___________________________

Employer Name ______________________________ Occupation__________________________________

Marital Status: Single Married Widowed Separated Divorced

Spouse Name ________________________ Employer ________________ Phone ___________________

Children (name, ages) ____

Emergency Contact

Name ____ Relationship____________________________

Home Phone _______________ Cell Phone _________________ Work Phone ________________________

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend or Family Member Name ____

Yellow Pages Website Presentation Sign Newspaper Other

Have you ever received chiropractic care? Yes No

If yes, when and where? ____

Do you have health insurance? Yes No If yes, company? _________________________________

Primary Insurance Info:

Insurance Company:____________________________ Policy Holder's Name ___________________________

Relation to Patient ________________________ Policy Holder's S.S. Number __________________________

Policy Number __________________________ Insured place of employment ___________________________

Do you have a Secondary Policy? Yes No

Insurance Company ___________________________ Policy Holder's Name ____________________________

Relation to Patient _____________________________ Policy Holders' S.S. Number ______________________

Policy Number ________________________________ Insured place of employment _____________________

Patient Case History

I. Health Complaints

☐ I have no health complaints, I am interested in prevention and health maintenance (skip to section II)

What is your **primary** complaint? ____

List other health complaints on the following lines:

1 ____________________________ 2 ____________________________

3 ____________________________ 4 ____________________________

5 ____________________________ 6 ____________________________

How long have you been experiencing the **primary** complaint? ______________________________

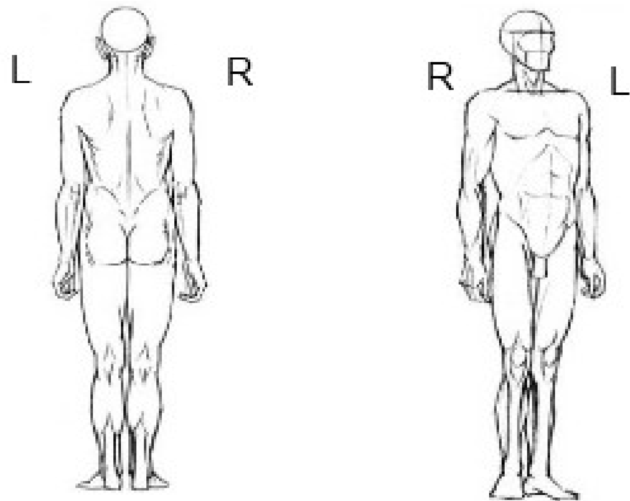
How does the **primary** complaint feel? ☐ dull ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ spasm ☐ other______

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

What makes your **primary** complaint better? ______________________________________

What do you believe is causing your **primary** complaint? ______________________________

Please mark the areas of all of your complaints on the diagrams to the right



II. Health History

Are you pregnant? Yes No If yes, how many weeks? ______________

How often do you use tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10-20 ☐ >20

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10-20 ☐ >20

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10-20 ☐ >20

How many glasses of water do you drink each day? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9+

How many times do you eat per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >5

How many servings of fruits and vegetables do you eat per day? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ >9

How often do you exercise? ☐ daily ☐ 5x/week ☐ 4x/week ☐ 3x/week ☐ 2x/week ☐ 1x/week ☐ never

How long do your workouts last? ☐ <30 minutes ☐ 30 minutes ☐ 1 hour ☐ >1 hour

What are your exercise activities? (mark all that apply)

☐ walking ☐ swimming ☐ weight lifting ☐ stretching/flexibility ☐ resistance bands
☐ running/treadmill/rowing ☐ yoga/palates ☐ group exercise classes ☐ other__________________

Please mark any of the following that apply to you?

☐ Headaches	☐ Wrist/Hand Pain	☐ Hepatitis	☐ Low Back Pain
☐ Seizures	☐ Upper Back	☐ Gallbladder Removed	☐ Hip Pain
☐ Multiple Sclerosis	☐ Mid Back Pain	☐ Diabetes	☐ Knee Pain
☐ Visual Problems	☐ Asthma	☐ Anemia	☐ Ankle/Foot Pain
☐ Allergies/Sinus	☐ Chest Pain	☐ Irritable Bowel Syndrome	☐ Cancer
☐ Ringing In Ears	☐ High Cholesterol	☐ Digestive Problems	☐ Arthritis
☐ Neck Pain	☐ High Blood Pressure	☐ Constipation	☐ Autoimmune Disease
☐ Hypothyroidism	☐ Acid Reflux/Indgestion	☐ Hemorrhoids	☐ Fibromyalgia
☐ Shoulder Pain	☐ Muscle Spasms/Cramps	☐ Menstrual Issues	☐ Weight (loss or gain)
☐ Elbow Pain	☐ Ulcers	☐ Urinary Difficulties	☐ Other____________________

III. Hospitalization, Surgeries and Injuries

Do you have a pacemaker? ☐ yes ☐ no
Have you had knee or hip replacement surgery? ☐ yes ☐ no
Have you had breast implant surgery? ☐ yes ☐ no
Do you have any other implantable medical device in your body? ☐ yes ☐ no
Please list any hospitalizations, surgeries or injuries that you have had (if none, write NONE):

Date Description

1 ____

2 ____

3 ____

4 ____

5 ____

IV. Medications and Supplements

Are medications (prescription or over-the-counter) necessary for you to have relief and/or to function?
☐ yes ☐ no

Please list any supplements and/or medications (RX and OTC) you are currently taking and why (if none, write NONE)

1 ______________________________ 5 ______________________________

2 ______________________________ 6 ______________________________

3 ______________________________ 7 ______________________________

4 ______________________________ 8 ______________________________

V. Genetic History

Have any of your blood relatives had any of the following conditions? If yes, please list who (if none, write NONE)

Heart Disease______________________ Stroke______________________

Cancer______________________ Arthritis______________________

Diabetes______________________ Auto-Immune Disease______________________

What types of care are you seeking? (mark all that apply)

- ☐ Injury prevention
- ☐ Nutritional and supplement counseling
- ☐ Health education classes
- ☐ Balance and coordination training
- ☐ Spinal and body alignment
- ☐ Treatment for pain
- ☐ Range of motion, mobility, or flexibility therapy
- ☐ Strengthening and stamina exercise
- ☐ Other ______________

______________________________ ______________________

Patient or guardian signature Date