

Name _____ Date _____
Address _____ City _____ State _____ ZIP _____
Phone (H) _____ Soc Sec Number _____ Date of Birth _____ Age _____
Phone (Cell) _____ E-mail address _____
Marital Status S M D W Number of Children _____ Have you been here before? Y N When? _____
Occupation _____ Employer _____ Years there _____
Employer's Address _____ City _____ State _____ Phone (W) _____
Spouse's Name _____ Date of Birth _____ Spouse is the policy holder? Y N
Occupation _____ Employer _____

How did you hear about this office? _____
Are you covered by Medicare? Y N Are you covered by State Insurance Aid? Y N
Do you have group, union or other personal health insurance? Y N

What is your major complaint? _____

How did you do this? _____
How long have you had this? _____ Have you had this before? Y N When? _____
Have you missed work? Y N How long were you out of work? _____
Is this condition getting worse? Y N Is this problem constant or does it come and go? _____
How long since you really felt good? _____

What activities aggravate your condition? [] Working [] Lifting [] Stooping [] Standing [] Sitting [] Bending
[] Laying Down [] Walking [] Daily Routine [] Other: _____
My pain is better when I: [] Rest [] Use Ice [] Use Heat [] Stretch [] Move Around [] Work [] Stand [] Sit
[] Chiropractic Adjustment [] Lay Down [] Massage [] Walk [] Take Time off From Work
[] Use Ointment, What? _____ [] Take drugs, What? _____

List date and type of surgeries or hospitalizations _____

Smoking Status: [] Never smoke [] Former Smoker [] Current – sometimes smoker [] Current – every day smoker

Do you have any medication allergies: Y N What? _____

Are you currently take any medications? Y N What, mg? _____

What non-prescription drugs, vitamins or supplements are you taking? _____

Other doctors seen for this condition _____

Have you had any X-ray, MRI or CT scans? Y N For What? _____

Family doctor _____ Date of last visit _____ For what? _____

Have you ever seen a Chiropractor? Y N Who? _____ For what? _____

Date of last visit to a Chiropractor _____ Date of last x-rays by a Chiropractor _____

Do you have a pacemaker? Y N Do you have now or have ever had any type of cancer? Y N

Do you have now or have ever had any type of infection? Y N

Other complaints: _____

All of the above information is true and correct. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment for any reason, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ **Date** _____

NECK

Pain in neck	Y N	Pinched nerve in neck	Y N
Neck pain with movement	Y N	Neck feels out of place	Y N
Bending head forward	Y N	Muscle spasm in neck	Y N
Bending head backward	Y N	Grinding sounds in neck	Y N
Turning head	L R	Popping sounds in neck	Y N
Bending head	L R		

SHOULDERS

Pain in shoulder joints	L R	Can't raise arm above head	L R
Pain across shoulders	Y N	Tension in shoulders	Y N
Bursitis in shoulders	L R	Pinched nerve in shoulders	L R
Arthritis in shoulders	L R	Muscle spasm in shoulders	L R
Can't raise arm above shoulders	L R		

ARMS & HANDS

Pain in upper arm	L R	Pain in forearm	L R
Pain in elbow	L R	Pain in hands	L R
Moving aggravates the pain	L R	Pain in fingers	L R
Tennis elbow	L R	Pins & needles in arm	L R
Arms are numb/go to sleep	L R	Pins & needles in fingers	L R
Fingers are numb/go to sleep	L R	Hands cold	L R
Arthritis/swelling in hands	L R	Loss of grip strength	L R

LOW BACK

Upper low back pain	Y N	Sacroiliac (SI) or hip pain	L R
Lower low back pain	Y N	Slipped, bulging/herniated disk	Y N
Low back feels out of place	Y N	Muscle spasm in lower back	Y N

HIPS, LEGS & FEET

Pain in buttocks	L R	Pain in hip joint	L R
Pain down leg	L R	Knee pain	L R
Leg cramps	L R	Foot cramps	L R
Pins & needles feeling	L R	Cold feet	L R
Numbness in leg	L R	Numbness in toes	L R
Swollen feet	L R	Swollen ankle	L R

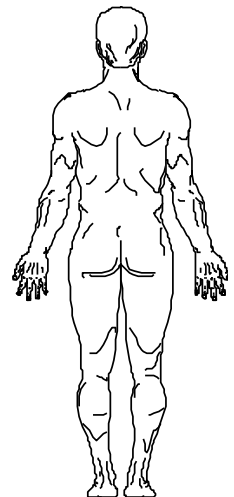
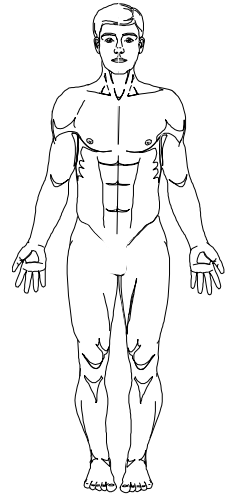
WOMEN ONLY

Menstrual pain	Y N	Cramping	Y N
Irregularity	Y N	Are you pregnant	Y N

MEN ONLY

Trouble starting urination	Y N	Excessive night urination	Y N
Prostate pain or swelling	Y N	Frequent urination	Y N

Please use the pictures below and mark your problem with an X.



Other remarks below:

Review Of Systems

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Where do you currently reside? (circle one) Independently In an Assisted Living Facility In a Nursing Home

Gastrointestinal

Nausea No Yes
 Vomiting No Yes
 Heartburn No Yes
 Food sticking in throat No Yes
 Painful swallowing No Yes
 Vomiting blood No Yes
 Black Stool No Yes
 Red blood in stool No Yes
 Abdominal pain No Yes
 Diarrhea No Yes
 Loss of appetite No Yes
 Early satiety (feeling full fast) No Yes
 Bloating No Yes

Constitutional

Recent weight gain # of pounds _____ No Yes
 Recent weight loss # of pounds _____ No Yes
 Fever No Yes
 Fatigue No Yes

Neurological

Seizures No Yes
 Headaches No Yes
 Loss of memory No Yes
 Light-Headedness No Yes
 Fainting No Yes
 Sinus Issues No Yes
 Location: _____

Dermatology

Rash No Yes
 Dimpled/orange peel breast No Yes

HEENT

Sore throat No Yes
 Hoarseness No Yes
 Loss of taste No Yes
 Loss of balance No Yes
 Loss of hearing No Yes
 Pain in ears No Yes
 Ringing in ears No Yes
 Buzzing in ears No Yes
 Dizziness No Yes
 Vision Issues No Yes

Cardiovascular

Abnormal heart rhythm No Yes
 Chest pain No Yes
 Palpitations No Yes

Respiratory

Cough No Yes
 Shortness of breath on exertion No Yes
 Shortness of breath at rest No Yes
 Wheezing No Yes

Genitourinary

Frequent urination No Yes
 Kidney failure/dialysis No Yes
 Painful urination No Yes
 Date of last menstrual period _____ No Yes
 Hypoglycemia No Yes

Psychiatric

Dementia No Yes
 Depression No Yes
 Anxiety No Yes
 Irritable No Yes

Past Surgical History

Abdominal Surgery No Yes
 What type _____
 Appendectomy No Yes
 Cancer Surgery No Yes
 What type _____
 Coronary Artery Bypass (CABG) No Yes
 Coronary Stent No Yes
 Cosmetic Surgery No Yes
 What type _____
 Defibrillator No Yes
 If yes, we need a copy of the card
 Gallbladder Removal No Yes
 Heart Valve Replacement No Yes
 Hemorrhoid Removal No Yes
 Hip, Shoulder, Knee replacement within 1 year No Yes
 Hysterectomy (TAH) No Yes
 Laparoscopy No Yes
 Pacemaker No Yes
 Salpingoophorectomy (BSO) (Tube and Ovary removal) No Yes
 Tonsillectomy No Yes
 Vascular Bypass/grafts within 1 yr. No Yes

Hospitalizations (non-Surgical) & Date

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Medical History

Ascites (extra fluid in abdomen) No Yes
 Asthma No Yes
 Bleeding Disorder No Yes
 Cancer What type _____ No Yes
 Congestive Heart Failure (CHF) No Yes
 Coronary Artery Disease (CAD) No Yes
 Depression No Yes
 Diabetes No Yes
 Emphysema or COPD No Yes
 Endometriosis No Yes
 Gallstones No Yes
 Heart Arrhythmia (A. Fib/SVT/A Flutter) No Yes
 Heart Attack No Yes
 Hepatitis No Yes
 High Blood Pressure No Yes
 Kidney Failure No Yes
 Kidney Stones No Yes
 Liver Disease No Yes
 Migraine Headaches No Yes
 Pancreatitis No Yes
 Peripheral Vascular Disease No Yes
 Rheumatic Fever No Yes
 Seizures No Yes
 Sleep Apnea No Yes
 Stomach Ulcer No Yes
 Stroke/TIA No Yes
 Thyroid Disease No Yes
 Valvular Heart disease or Endocarditis No Yes

Family Medical History (not you) If Yes, please list the relative and age

Colon Cancer No Yes _____
 Colon Polyps No Yes _____
 Inflammatory Bowel Disease (IBD) No Yes _____
 Cancer of:
 Endometrial No Yes _____
 Esophagus No Yes _____
 Kidney No Yes _____
 Ovarian No Yes _____
 Pancreas No Yes _____
 Small Bowel No Yes _____
 Stomach No Yes _____

Social History

Marital Status: Single _____ Married _____ Separated _____
 Divorced _____ Widowed _____
 Children: No _____ Yes _____ How Many _____
 Use of Alcohol: None _____ Yes _____ How Much _____
 Used of Tobacco: Never _____ Quit _____ Yes _____ How Much _____
 Caffeine Use: No _____ Yes _____
 Sleep: Hours _____

Drug Allergies/ Intolerance

Current Medications/Doses

Are you taking any blood thinners? No _____ Yes _____
 What non-prescription drugs, vitamins or supplements are you taking?

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility inform that doctor's office of any changes in my medical status. I authorize the health staff to perform the necessary services I may need and release information to others if necessary for my care.

Signature of patient

Date