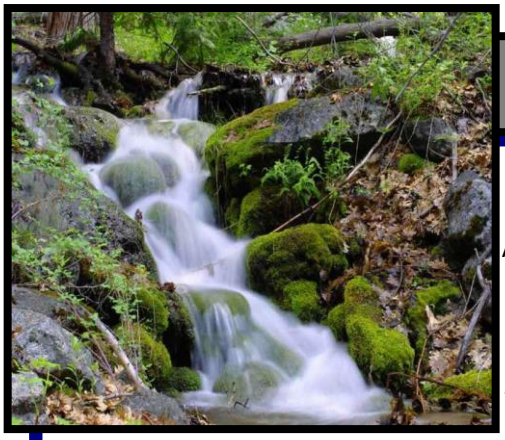


WELCOME

PATIENT INFORMATION

Appt. Date: _____ *Referred By:* _____

Name (first, last):_____

Preferred Name: _____

Sex ☐ M ☐ F Age _____ Date of Birth: ____/____/_____

Address _____

City _____ State _____ Zip _____

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

Employer _____ Work Phone (_____)_____

Occupation:_____ Email: _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow Spouse's Name _____

Emergency Contact: _____ Relationship_____ Phone # (___) _____

PATIENT CONDITION

Primary Complaint(s) _____

Secondary Complaint(s): _____

Are your complaints due to an Accident? ☐ NO ☐ YES

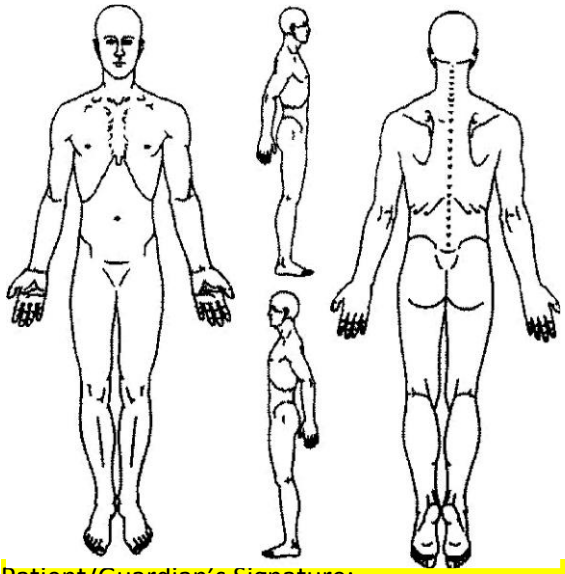
If yes, what type? ☐ Work ☐ Auto ☐ Personal Date of Accident_____

Have you seen any doctors for your primary/secondary complaints: ☐ YES ☐ NO

If yes, please list the doctor specialty & for how long you were seen:

_____

Is this condition getting progressively worse? □Yes □ No □ Unknown



PLEASE MARK the areas on the diagram using the following letters to describe your symptoms:

R = **R**adiating

B = **B**urning

D = **D**ull

A = **A**ching

N = **N**umbness

S = **S**harp/Stabbing

T = **T**ingling

P = **P**ain

Patient/Guardian's Signature: _____ Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

HEALTH HISTORY

Family History: Does anyone in your family suffer with the same or other chronic conditions?

❑ No ❑ Yes If yes whom & what condition(s): _____

Past Trauma History: *Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause* ***Postural Distortions*** *(misalignments of the spine) and lead to our current health problems*.

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents

Example: 11/11/1985 Type of Collision: Rear end-15 mph Injuries: Neck Whiplash/Neck on Lt.

Date:___/__/____ Type of Collision: ☐Front ☐Side ☐Rear Speed ____ Injuries: _____ ☐Lt ☐Rt

Date:___/__/____ Type of Collision: ☐Front ☐Side ☐Rear Speed ____ Injuries: _____ ☐Lt ☐Rt

B. Sports Injuries (if there are too many to list write the name of the sport and "MANY" next to it.)

Example: 3/3/1995 Type of Sport: Basketball Type of Injury: Sprained Right Knee

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐Lt ☐Rt

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐Lt ☐Rt

C. Slips, falls, Other (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 5/5/2000 Type of Injury: Slipped on ice & bruised Left Elbow

Date:___/__ /_____ Type of Injury_____ ☐Lt ☐Rt

Date:___/__ /_____ Type of Injury: _____ ☐Lt ☐Rt

Past Health Conditions:

Please list: *when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain)*

Past Health Issue: _____

Past Health Issue: _____

Are any of these past conditions due to an accident? ☐ YES ☐ NO Date of Accident_____

Have you seen any doctors for this condition: ☐ YES ☐ NO

If yes, list the doctor specialty & for how long you were seen. _____

List any past hospitalizations and/or surgeries:

Surgeries:_____

List Hospitalizations Other Than Surgeries:_____

Patient/Guardian's Signature: _____ Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

CURRENT CONDITIONS

Please mark to indicate if you have any of the following:

□ Hip Pain: Rt or Lt	□ Lung Problems	□ Kidney Disease	□ Prosthesis
□ Knee Pain: Rt or Lt	□ COPD	□ Liver Disease	□ Psychiatric Care
□ Foot Pain: Rt or Lt	□ Emphysema	□ Digestion Problems	□ Rheumatoid Arthritis
□ Shoulder Pain: Rt or Lt	□ Epilepsy	□ Migraines	□ Cancer & Type: _____
□ Elbow Pain: Rt or Lt	□ Fractures	□ Miscarriage	□ Dizziness/Loss of Balance
□ Wrist Pain: Rt or Lt	□ Glaucoma	□ Diarrhea/Constipation	□ Stroke
□ Neck Pain: Rt or Lt	□ Heartburn	□ Multiple Sclerosis	□ Arthritis
□ Upper Back Pain:Rt or Lt	□ Gonorrhea	□ Hemorrhoids	□ Thyroid Problems
□ Low Back Pain: Rt or Lt	□ Gout	□ Osteoporosis	□ Trouble Sleeping
□ Pain w/cough	□ Heart Disease	□ Pacemaker	□ Tuberculosis
□ Numbness in arms	□ Hepatitis	□ Parkinson's	□ AIDS / HIV
□ Numbness in legs	□ Hernia	□ Pinched Nerve	□ High / Low Blood Pressure
□ Asthma	□ Herniated Disc	□ Pneumonia	□ Vaginal Infections
□ Chest Pain	□ Herpes	□ Skin Problems	□ Impotence
□ Difficulty Breathing	□ High Cholesterol	□ Prostate Problems	□ Reproductive Problems

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ High Stress

SOCIAL HABITS: ☐ Smoking ☐ Alcohol ☐ Coffee/Caffeine ☐ Recreational Drugs

List any medications you currently take. (Prescription and non-prescription)

_____

Functional Assessment: Check any activities that are affected by your current conditions

☐ Sitting	☐ Running	☐ Sit to Stand	☐ Climbing
☐ Standing	☐ Pushing/Pulling	☐ Walking	☐ Dressing/Shaving
☐ Driving	☐ Dishes/Laundry	☐ Sleep/Rolling	☐ Bending
☐ Reading	☐ Lifting	☐ Computer Use	☐ Exercising/Sports

☐ Yard work/Gardening

Doctors Notes: _____

Patient/Guardian's Signature: _____ Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____