Patient Confidentiality Personal Data

Today's Date: _____ Date of Birth: _____

Patient Information

Name: _____ Preferred Name: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Cell Phone: _____ Work: _____ Home: _____
E-Mail: _____
Gender: M / F Marital Status: Single / Married / Other: _____
Name of Spouse: _____ Number of Children: _____
Employed: Y / N
Employer: _____ Occupation: _____
*Referred by: _____ Family/Friend/Co-Worker/Doctor/Other

Emergency Contact Information

Name: (*First Last*) _____ Cell Phone: _____
Relationship: Child / Parent / Spouse / Other: _____
Primary Care Physician: _____ Doctor's Phone: _____

Describe Major Complaint: _____
Describe and Secondary Complaints: _____
Describe WHEN and HOW this began: _____
_____
Grade Intensity/Severity of Complaint:
None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)
Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____
How frequent in the complaint present? Off & On / Constant
Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____
Head – Base of skull / Forehead / Sides-Temple R/L/Both
Arm – Across shoulder / Elbow / Hand-fingers R/L/Both
Leg – Hip / Thigh-Knee / Calf / Foot-Toes R/L/Both
Other area: _____
Does anything make the complaint better?
Ice/Heat/Rest/Movement/Stretching/OTC/Other_____
Does anything make the complaint worse?
Sit/Stand/Walk/Lying/Sleep/Overuse/Other _____
Which activities are being affected by this condition? _____

For this CURRENT condition, have you:

- Received any other treatment? None/DC/MD/PT/Massage/ER/Other:_____
  Where did you receive treatment? _____
- Had any diagnostic testing? X-rays/MRI/CT/Other:_____
  When and Where? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Please mark each of the conditions you have experienced in the last 6 months.
Many of the following conditions respond to Chiropractic treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems_____
- ☐ Leg Problems_____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of feeling
- ☐ Dizziness or light headed
- ☐ Frequent or recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed wetting
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear – ache/ringing/drainage
- ☐ Sinus / allergy problems
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ *None in this Category*

Mind/Stress
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ *None in this Category*

Surgeries: **NONE**

Date	Area of the Body	Reason

Endocrine, Hematologic and Lymphatic
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive thirst or urination
- ☐ Cold extremities
- ☐ Heat or cold intolerance
- ☐ Glandular or hormone problem
- ☐ Swollen glands
- ☐ Anemia
- ☐ Easily bruise or bleed
- ☐ Phlebitis
- ☐ Immune system disorder
- ☐ *None in this Category*

Skin and Breasts
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge
- ☐ *None in this Category*

Women only

Are you pregnant?
- ☐ **Yes – Due date _____ /_____ /_____**
- ☐ **No – *Last Menstrual Period***
  _____ /_____ /_____
- ☐ Infertility
- ☐ Painful or irregular periods
- ☐ Vaginal discharge
- ☐ Other:_____
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

List any medication you are currently taking: _____

_____

Comments: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____