


Patient Data
Date: _____

Title: Mr. Mrs. Ms Miss (check one)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Primary Phone:** (_____) _____ - _____

Secondary Phone: (_____) _____ - _____ **Cell Phone:** (_____) _____ - _____

Work Email: _____ **Home Email:** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided
Contact Method __ Primary Phone __ Secondary Phone __ Cell Phone __ Email

Date of Birth: ____/____/____ **Sex:** Male Female **Social Security Number:** _____ - _____ - _____

Marital Status: Single Married Other **Employment Status:** Employed Full Time Student Part Time Student Other (check one)

Employer Data
Name: _____

Address: _____ **Phone Number:** (_____) _____ - _____

City: _____ **State:** _____ **Zip Code:** _____

Insurance Data
Insurance Company: _____ **I.D. #:** _____ **Group:** _____

Subscriber: _____ **D.O.B.:** ____/____/____ **Sex:** Male Female

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____ **Employer Name:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Emergency Contact
Contact Name: _____ **Contact Phone:** (_____) _____ - _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

Name:

Is it okay to call you at work?

Yes No

How did you hear about our clinic? Or who referred you?

Family member Attorney Internet web site Health class
 Friend Internet Billboard Brochure
 Physician Newspaper ad TV Commercial Direct mail ad
 Employer Sign on building Radio Other _____

If you selected 'Internet' please indicate which website:

If you selected 'family member' or 'friend' please enter their name below:

If you selected 'physician' please enter their name and phone number below:

Name: _____ Phone Number: _____

Medical Conditions:

Arthritis Cancer Diabetes Heart Disease
 Hypertension Psychiatric Illness Skin Disorder Stroke

Surgeries:

Appendectomy Cardiovascular procedure Cervical disc procedure Hysterectomy
 Joint replacement Laminectomies Radical prostatectomy Transurethral prostate surgery

Allergies:

Eggs Fish and Shellfish Milk or Lactose Peanut
 Soy Sulfites Wheat/Gluten

Social History:

Caffeine used occasionally Caffeine used often Chew tobacco occasionally Chew tobacco often
 Drink alcohol occasionally Drink alcohol often Exercise not at all Exercise occasionally
 Exercise often Experience stress occasionally Experience stress often Smoke 1 pack or less per day
 Smoke more than 1 pack a day Wear seat belts always Wear seat belts never Wear seatbelts usually

Family History:

Arthritis (parent) Arthritis (sibling) Cancer (parent) Cancer (sibling)
 Cholesterol (parent) Cholesterol (sibling) Diabetes (parent) Diabetes (sibling)
 Heart problems (parent) Heart problems (sibling) High blood pressure (parent) High blood pressure (sibling)
 Psychiatric (parent) Psychiatric (sibling) Stroke (parent) Stroke (sibling)
 Thyroid (parent) Thyroid (sibling)

Substance Use:

Alcohol (past) Alcohol (present) Amphetamines (past) Amphetamines (present)
 Barbiturates (past) Barbiturates (present) Cocaine (past) Cocaine (present)
 Crystal Meth (past) Crystal Meth (present) Heroin (past) Heroin (Present)
 Marijuana (past) Marijuana (present)

Male Children:

Under 6 years Under 10 years Under 19 years

Female Children:

Under 6 years Under 10 years Under 19 years

Occupational Activities:

Administration Business owner Clerical/secretarial Computer user
 Construction Daycare/childcare Executive/legal Food service industry
 Health care Heavy equipment operator Heavy manual labor Home services
 Household Light manual labor Manufacturing Medium manual labor

Name:

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

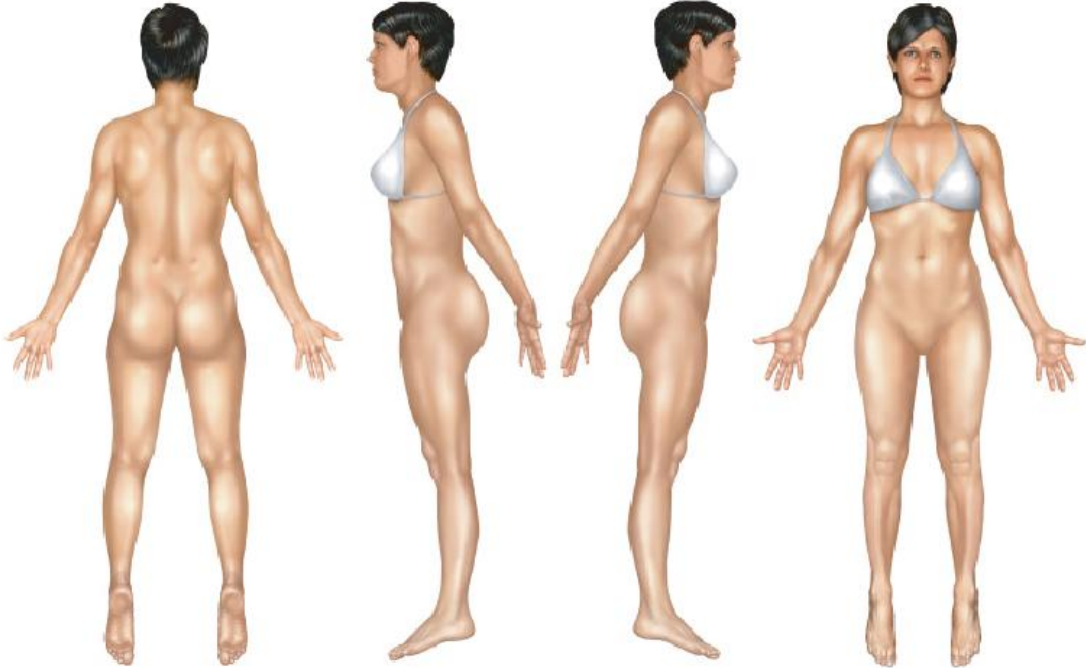
= Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly
(76-100% of the day)

Frequently
(51-75% of the day)

Occasionally
(26-50% of the day)

Intermittently
(0-25% of the day)

What describes the nature of your symptoms?

Sharp

Dull ache

Numb

Shooting

Burning

Tingling

Stabbing

How are your symptoms changing?

Getting better

Not changing

Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

0 None

1

2

3

4

5

6

7

8

9

10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

Not at all

A little bit

Moderately

Quite a bit

Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- All of the time Most of the time Some of the time A little of the time
 None of the time

In general, would you say your overall health right now is....

- Excellent Very good Good Fair
 Poor

Who have you seen for your symptoms:

- No one Other Chiropractor Medical Doctor Physical Therapist
 Other

What treatment did you receive for your symptoms?

- Adjustments Physical Therapy Medication Surgery
 Other

When did you receive this treatment?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 – 2 years ago 2 – 5 years ago 5 – 10 years ago

What tests have you had for your symptoms?

- X-rays MRI CT Scan Other

When were these tests done?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 - 2 years ago 2 – 5 years ago 5 – 10 years ago

Have you had similar symptoms in the past?

- Yes No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- This Office Other Chiropractor Medical Doctor Physical Therapist
 Other

What is your occupation?

- Professional/Executive White Collar/Secretarial Tradesperson Laborer
 Homemaker Full-time Student Retired Other

If you are not retired, a homemaker or a student, what is your work status?

- Full-time Part-time Self-employed Unemployed
 Off work Other