CONFIDENTIAL PATIENT INFORMATION (ADULT)

*Dear Patient, **Please read and complete this questionnaire in detail**. Your answers will help us determine if chiropractic can assist you. If we do not seriously believe your condition will respond satisfactorily, we will not accept your case.*

Name: First _____MI _____Last _____Age: _____
Address: _____City: _____State: _____Zip: _____
Phone: (H): _____ (C): _____ (W): _____
E-Mail Address: _____
Occupation: _____ Employer: _____ DOB: _____
Marital Status: M W D S Spouse's Name:_____
Children's Name & Ages: _____
_____
Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? _____
Research shows that your spine should be checked regularly. When was your last spinal examination, including x-rays?
_____

Insurance Information

If you are insured and wish for us to assist you in submitting your claims, please provide us with your driver's license and insurance card so that we may make a copy and verify your coverage in this office.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Briefly describe the chief area of complaint, including the effect it has had on your life. _____
_____
On a scale of 0-10 (0=no pain; 10=extreme pain), how would you grade the pain…
1). Currently_____ 2). At its best_____ 3). At its worst_____
Since the problem started, is it … About the same Getting better Getting worse
What makes it worse? _____
Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure
Do you suffer from any condition other than that which you are now consulting us? Yes / No Please explain._____
_____
When did your problem first appear? _____Have you experienced this in the past? Yes / No
Doctors seen for this problem: Chiropractor(s) _____ Medical Doctor(s) _____
Has anyone in your family experienced similar problems? Y / N If so, who? _____

BODY SIGNALS

Please circle **ALL** symptoms (body signals) you have ever had, even if they do not seem related to your current problem.

Headaches	Pins and needles in legs	Fainting	Neck pain
Pins and needles in arms	Loss of smell	Back pain	Loss of balance
Dizziness	Buzzing in the ears	Ringing in the ears	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Neck stiff	Cold hands	Cold feet
Diarrhea	Constipation	Fever	Hot flashes
Cold sweats	Lights bother eyes	Problem urinating	Heartburn
Mood swings	Menstrual Pain	Menstrual Irregularity	Ulcers

Stress can cause or accelerate spinal damage. Rate your stress level over the past 90 days. Low/ 1 2 3 4 5 6 7 8 9 10 /High
Poor posture leads to poor health and often indicates a spinal condition.
How would you rate your posture? Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent
Prescription medications may cause various side effects, hide the severity of health conditions and or hinder the body's ability to heal. What medications are you currently taking? _____
_____

Patient's Signature: X _____Date: _____

Family History and Personal History Information

FAMILY HISTORY (If your mom had it put an M, if dad put a D, and if both had it put a B.)

( ) High Blood Pressure ( ) Heart Attack ( ) Emphysema ( ) Asthma ( )Ulcer / Digestive Issues
( ) Diabetes ( ) Kidney Disease ( ) Mental Illness ( ) Cancer
( ) HIV Positive ( ) Thyroid Disease ( ) Circulation Problem
( ) Arthritis /Rheumatoid ( ) Seizures/Convulsions ( ) Stroke (Indicate Age at first stroke Mother ___ Father ___)

ACTIVITIES OF DAILY LIVING

Check each of the activities which you have difficulty performing or causes pain when performing.

General

___ Walking ___ Standing ___ Running ___ Sitting
___ Lifting Children ___ Bending ___ Climbing Stairs ___ Reading
___ Laying in Bed ___ Chewing ___ Swimming ___ Getting in/out of Car
___ Playing Piano ___ Using Computer ___ Kneeling ___ Sexual Intercourse
___ Sports (List:_____) ___ Sleeping ___ Using Telephone ___ Other_____

House and Yard Work

___ Laundry ___ Making Beds ___ Vacuuming ___ Doing Dishes
___ Cooking ___ Carrying Groceries ___ Caring for Pets ___ Shoveling Snow
___ Mowing Lawn ___ Raking Leaves ___ Gardening ___ Other_____

Personal Grooming

___ Combing Hair ___ Shaving ___ In/Out Bathtub ___ Brush Teeth
___ Dressing Yourself ___ Other: _____

Travel

___ Driving ___Riding (Passenger) Minutes per Day spent in ____Car ___ Bus or Other:_____

REVIEW OF SYSTEMS (Check ones that you have now or have had in the past.)

Now	Past		Now	Past		Now	Past	
___	___	Seizures	___	___	Vertigo	___	___	Dizziness
___	___	Hand Trembling	___	___	Loss of Sensation	___	___	Incoordination
___	___	Loss of Facial Expression	___	___	Weak Grip	___	___	Paralysis
___	___	Difficulty w/Speech	___	___	Tingling	___	___	Loss of Memory
___	___	Numbness	___	___	Weight Gain	___	___	Weight Loss
___	___	Breast Changes	___	___	Heat Intolerance	___	___	Cold Intolerance
___	___	Hyperventilation	___	___	Insecurity	___	___	Depression
___	___	Troubled Sleep	___	___	Irritable	___	___	Undecidedness
___	___	Timid	___	___	Hallucinations	___	___	Loss of Memory
___	___	Drug Dependency	___	___	Drug Addiction	___	___	Alcoholism
___	___	Suicidal Thoughts	___	___	Extreme Worry	___	___	Sexual Problems
___	___	Muscle Pain	___	___	Muscle Weakness	___	___	Muscle Cramps
___	___	Muscle Twitching	___	___	Joint Stiffness	___	___	Joint Pain

PAST MEDICAL HISTORY (Check ones that you have had in the past.)

___ Hay Fever	___ Mumps	___ Rheumatic Fever	___ Allergies	___ Sexual Problems
___ Cancer	___ Tumor	___ Blood Disease	___ Leukemia	___ Heart Trouble
___ Depression	___ Phlebitis	___ Hypertension	___ Stroke	___ Mental Illness
___ Jaundice	___ Polio	___ Skin Trouble	___ Gallstones	___ Liver Trouble
___ Hepatitis	___ Parasites	___ Epilepsy	___ Paralysis	___ Prostate Problem
___ Alcoholism	___ Dysentery	___ Varicose Veins	___ Diabetes	___ Gout
___ Syphilis	___ Migraine	___ Hemorrhoids	___ Nervous Breakdown	___ Gonorrhea
___ Ulcers	___ Angina	___ Bladder Trouble	___ Kidney Stones	___ Kidney Infections

___ Other_____

IMMUNIZATIONS (Check ones that you have had in the past.)

___ DPT	___ Mumps	___ Smallpox	___ Typhoid	___ Tetanus	___ Chicken Pox
___ HPV	___ Influenza	___ Polio	___ MMR	___ HPV	___ Pneumococcal
___ Measles	___ Other_____				

Print Name:_____ Date:_____

Signature:_____