WELCOME!

PATIENT INFORMATION FORM

Name _____ Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ ❑ Male ❑ Female Age _____ Birth date _____

Occupation _____ Patient Employer/School _____

Employer/School Address _____ Employer/School Phone _____

Marital Status ❑ W ❑ S ❑ M ❑ D Spouse's Name _____

Spouse's Employer _____ Spouse's Work or Cell Phone _____

Whom may we thank for referring you? _____

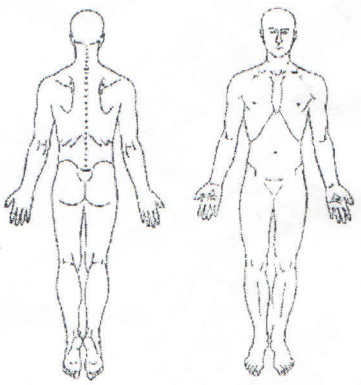
PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

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

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

type of pain ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning

❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down.

HEALTH HISTORY

What treatment have you already received for this condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None

❑ Other _____

Name and address of other doctor(s) who have treated you for this condition _____

Date of last

Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

❑ Yes	❑ No	AIDS/HIV	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Measles	❑ Yes	❑ No	Rheumatic Fever
❑ Yes	❑ No	Alcoholism	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Migraine Headache	❑ Yes	❑ No	Scarlet Fever
❑ Yes	❑ No	Allergy Shots	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Miscarriage	❑ Yes	❑ No	Stroke
❑ Yes	❑ No	Anemia	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Mononucleosis	❑ Yes	❑ No	STD
❑ Yes	❑ No	Anorexia	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No	Suicide Attempt
❑ Yes	❑ No	Appendicitis	❑ Yes	❑ No	Goiter	❑ Yes	❑ No	Mumps	❑ Yes	❑ No	Thyroid Problems
❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Gonorrhea	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No	Tonsillitis
❑ Yes	❑ No	Asthma	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Tuberculosis
❑ Yes	❑ No	Bleeding Disorders	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Parkinson's Disease	❑ Yes	❑ No	Tumors, Growths
❑ Yes	❑ No	Breast Lump	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Pinched Nerve	❑ Yes	❑ No	Typhoid Fever
❑ Yes	❑ No	Bronchitis	❑ Yes	❑ No	Hernia	❑ Yes	❑ No	Pneumonia	❑ Yes	❑ No	Ulcers
❑ Yes	❑ No	Bulimia	❑ Yes	❑ No	Herniated Disk	❑ Yes	❑ No	Polio	❑ Yes	❑ No	Vaginal Infections
❑ Yes	❑ No	Cancer	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Prostate Problem	❑ Yes	❑ No	Whooping Cough
❑ Yes	❑ No	Cataracts	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Prosthesis	Other _____		
❑ Yes	❑ No	Chemical Dependency	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Psychiatric Care			
			❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Rheumatoid Arthritis			
❑ Yes	❑ No	Chicken Pox	❑ Yes	❑ No	Liver Disease						

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better in tests in school
- ❑ Not be dependent on the over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less cold and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

Other _____

Exercise

- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

Work Activity

- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

Habits

- ❑ Smoking — Packs/Day _____
- ❑ Alcohol — Drinks/Weeks _____
- ❑ Coffee/Caffeine Drinks — Cups/Day _____
- ❑ High Stress Level — Reason _____

Are you pregnant? ❑ Yes ❑ No Date of onset of last menstrual period _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/ Herbs/ Minerals