CONFIDENTIAL PATIENT INFORMATION/ MAJOR MEDICAL

Name _____ S.S.N._____ Date _____

Address _____ City/State _____ ZIP _____

D.O.B _____ Height/Weight _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

Cell Phone _____ Email address _____

Spouse/Partner Name _____

Emergency Contact Name_____ ER Contact Phone # _____

Whom may we thank for referring you to us _____

Symptoms developed from: Work Injury ____ Auto Accident ____ Other _____

Have you ever had similar symptoms? (dates) _____

Have you ever had pain in other areas of your spine? (dates) _____

Dates of previous auto accidents _____

List surgical operations w/ dates _____

List any medications you are on _____

Other doctors consulted for this condition? (dates) _____

Do you have a past history of injuries involving: (dates) ankles _____ knees _____

hips _____ wrists _____ elbows _____ shoulders _____

Have you had X-Rays taken of your spine in the last 7 years? _____

Dates of last physical exam _____ Any unusual findings _____

Do you exercise regularly? _____ Types and How often? _____

Do you smoke/use tobacco? _____ If so, how often? _____

Do you drink alcohol? _____ If so, how often? _____

Men: Date of last prostate exam _____ Date of last colon exam _____

Any unusual Findings_____

Women: **Date of last pap smear _____ Date of last mammogram _____**

Any unusual findings _____

Are you pregnant? _____ Due Date _____ Trying to get pregnant? _____

Do you have children? _____ How many? _____

Do you have breast implants? _____ Taking Birth Control?_____

Family History: **(List any significant diseases, i.e.: diabetes, cancer, etc.) Are you adopted? _____**

Mother_____ Father _____

Grandparents _____ Aunt/Uncle/Siblings _____

Chief Complaint _____

ONSET **(what were you doing when injury occurred) _____**

PROVOKING **(what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____**

PALLIATIVE **(what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other ___**
_____

QUALITY **(describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __**
_____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY **On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____**

PATTERN **(time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____**

Complaint #2 _____

PROVOKING **(what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____**

PALLIATIVE **(what makes it feel better)** Circle- **Ice / Heat / Lying / Pain Med. / Stretching / Other ___**
_____

QUALITY **(describe the pain)** Circle- **Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __**
_____

Any sensations radiating into the following -Circle- **Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____**

Describe the radiating -Circle- **Sharp / Dull / Tingling / Numbness / Prickling / Other _____**

SEVERITY **On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____**

PATTERN **(time of day most aggravated)** Circle- **Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____**

CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

_____ Headache
_____ Allergies
_____ Dizziness
_____ Deafness
_____ Ringing in Ears
_____ Loss of Balance
_____ Fainting
_____ Eye Pain
_____ Failing Vision
_____ Nosebleeds
_____ Sinus Infection
_____Blackouts

CHEST

_____ Chest Pain
_____ Difficulty Breathing
_____ Asthma

ABDOMEN

_____ Difficult Digestion
_____ Abdominal Cramps
_____ Diarrhea
_____ Constipation
_____ Nausea
_____ Change in Urinary Function
_____ Change in Bowel Function

OTHER

_____ Loss of Sleep
_____ Nervousness
_____ Depression
_____ Fever
_____ HIV+/Aids
_____ Change in Menstrual Cycle
_____ Pregnant
_____ Hemorrhoids
_____Acid Reflux
_____Heartburn
_____ Other_____

PLEASE CHECK ANY OF THE FOLLOWING YOU'VE HAD

_____ Alcoholism **_____ Allergies** **_____ Anemia**
_____ Appendectomy **_____ Arteriosclerosis** **_____ Arthritis**

_____ Cancer	**_____ Colitis**	**_____ Diabetes**
_____ Diphtheria	**_____ Eczema**	**_____ Emphysema**
_____ Gall Bladder Problems	**_____ Goiter**	**_____ Epilepsy**
_____ Heart Disease	**_____ Hepatitis**	**_____ Kidney Stone/**
_____ Liver Problems	**_____ Malaria**	**Infection**
_____ Multiple Sclerosis	**_____ Pleurisy**	**_____ Migraines**
_____ Polio	**_____ Prostate Problems**	**_____ Pneumonia**
_____ Thyroid Trouble	**_____ Tuberculosis**	**_____ Scarlet Fever**
_____ Venereal Disease	**_____ Whooping Cough**	**_____ Ulcers**

Signature _____ Date _____

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

_____ Do **not** want a copy _____ Received a copy

Printed Name: _____

Signature _____ Date _____