

General Information

Name: _____ Today's Date: _____ Age: _____ Sex: Male Female
Height: ___ ft. ___ inches Weight: _____ lbs. Occupation: _____
Referring Physician: _____ Primary Care Physician (if different): _____

Reason for Visit – Current Condition

Briefly State the Reason for Today's Visit: _____

Is your condition a result of a(n): Auto Accident* Work Related Injury* Personal Injury* Not Sure
 Other (please explain): _____

*Please ask for and complete relevant questionnaire and agreement

Date of Injury (or Date Problem First Noticed): _____ Is this a new problem? Yes No

If **NO**, have you previously sought treatment? Yes No

If **YES**, who provided treatment: _____ City, State: _____

What did the previous treatment consist of, and what were the results? _____

Are you currently experiencing any: weakness numbness radiating pain Where? _____

Do you feel your condition is getting: better worse staying the same

Please **circle** the current severity of your pain from 0 (no pain) to 10 (most extreme pain):

0 1 2 3 4 5 6 7 8 9 10

Are you currently under the care of a chiropractor? Yes No

If **YES**, who: _____

Past Medical History

Please list all previous surgeries, fractures, or serious illnesses:

Date	Type of Surgery/Fracture/Illness	Date	Type of Surgery/Fracture/Illness

Past Medical History (CON'T)

Please list ALL medications you are currently taking (prescription, over the counter, and herbal/nutritional supplements):

Medication	Dosage	Medication	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you have any allergies? Yes No If YES, please list your allergies: _____

Have **YOU** had (or currently have) any of the following (Please Check):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatoid Arthritis	_____

Are you currently a resident of a Skilled Nursing Facility or receiving Home Health Services? Yes No

Social History

Single Married Divorced Separated Widowed

Do you have children? Yes No If **YES**, How Many? _____ Do you live alone? Yes No

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Are you on a special diet? Yes No If **YES**, Please describe _____

History of substance abuse? Yes No If **YES**, Please describe _____

Do you smoke? Yes No If **YES**, ____ packs per day for ____ years

Have you quit smoking? Yes No If **YES**, when did you quit?

This year >1 year >5 years >10 years

Previously smoked ____ packs per day for ____ years

Do you drink alcohol? Yes No If **YES**, how often?

Daily 1-2 x/week 1-2 x/month 1-2 x/year

Signature

Patient (or Legal Guardian) Signature: _____ **Date:** _____