

Patient Information & History

Please fill this out as thoroughly as possible. Thank you.

Name: First _____ Last _____ Middle _____ Nickname _____

Address: _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Cell _____ Other _____

Birthday: ____/____/____ Gender: M F Marital Status: M S D SSN: _____

Occupation: _____ Employer _____

Who may we thank for referring you to our office? _____

Will you be paying with insurance? Y N If yes; please present your insurance card and ID to the front desk.

We will do our best to provide information regarding your insurance coverage; however ultimately it is the patient's responsibility to understand and pay for any deductibles, co-pays and non-covered procedures at the time of service.

I acknowledge and understand that it is my financial responsibility to pay for services rendered when insurance does not cover certain services, if I am meeting a deductible, if I have co-insurance/co-pay, or if I do not have insurance coverage.

Signature: _____ Date ____/____/____

What brings you here today (Briefly describe your symptoms)?

When did your symptoms begin? _____

How did your symptoms begin? _____

How often do you experience your symptoms? (Circle one) Constantly (76-100%) Frequently (51-75%)
Occasionally (26-50%) Intermittently (0-25%) Only once in a while Don't know _____

What, if anything, makes it feel better? _____

What makes it feel worse? _____

When is it worse? (circle one); morning afternoon evening waking up trying to sleep all the time

How much have your symptoms interfered with your usual daily activities; including both home and work? (Circle one)

Not at all A little bit Moderately Quite a bit Extremely

What **specific** activities are difficult, altered or impossible to perform due to your symptoms?

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Have you had this problem before? Yes No If yes, when? _____

What type of treatment did you have in the past? _____

Have you had treatment for your **current condition** (the reason you are here today)? Yes No

If yes, what type of treatment? _____

Was it helpful? Yes No A little Doctor's Name _____

May we contact the doctor to discuss your treatment plan? Yes No _____

What are your goals/expectations from treatment at this office? What would you like to be able to do/accomplish here?

Physical & Social History

Exercise within the last 6 months? None 1-2 times/week 3-5 times/week Daily

What type of exercise do you perform? _____

Do your symptoms interfere with your exercise (Describe how)? _____

Prior to your current condition, were you physically active? (Describe activities) _____

Hobbies/Activities of daily living: _____

Do you smoke? Yes No If yes, how much, how often and for how many years? _____

Do you drink alcohol? Yes No If yes, circle one: 1-2/week 2-5/week Daily Average more than 2/day

Do you drink caffeine? Yes No If yes, circle one: Occasionally 1-2 cups/day 2 or more cups/day # _____

Do you consume artificial sweeteners? If yes, in what and how much? _____

How many servings do you eat **each day**? (You can write fractions i.e. 1/7 or 2/7 if it is once or twice a week)

Fruits _____ Vegetables _____ Water (8oz) _____ Lean meat/fish _____ Legumes/Beans _____ Whole grain bread _____

Pasta/White Bread _____ Dairy _____ Red meat/pork _____ Sodas/sweet tea _____ Chips/Crackers _____

Fast food _____ Sweets/sugar _____ Nonfat/reduced fat foods _____ Frozen foods _____ Processed foods _____

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Please list any medications, vitamins or supplements you are currently taking. If you need more space let us know.

Prescription Medications/Over the counter medications & Supplements/Vitamins		
Name	Use	How much and How Often

Have you had or do you have any of the following conditions? **Circle all that apply to you.**

It looks like a lot of questions, but sometimes other conditions can mimic back or neck pain. Please answer completely.
If there is something not listed please write in the lines below this list.

General Symptoms	Gastro-Intestinal	Eye/Ear Nose/Throat	Respiratory	Genito-Urinary	Musculoskeletal	Cardio – Vascular	Endocrine/ Autoimmune	Women only
Allergies	Constipation	Earache	Asthma	Blood in urine	Backache	High Blood Pressure	Diabetes	Excessive flow
Dizziness	Diarrhea	Ringing in ears	Chronic cough	Frequent urination	Arthritis	High cholesterol	Thyroid problems	Irregular cycle
Headaches	Chron's	Chronic Sinus Infections	Bronchitis	Lack of bladder control	Scoliosis	Irregular heartbeat	MS	Painful periods
Chest pain	IBS	Tinnitus	Emphysema	Painful urination	Torn muscle	Stroke	Lupus	Cramps
Fainting	Abdominal pain	Blurry vision	Tuberculosis	Prostate cancer	Fractures	Heart attack	Rheumatoid Arthritis	Lump in breast
Sweats	Gall bladder trouble	Eye surgery	Spitting blood	Enlarged prostate	Swollen joints	Bypass surgery	Scleroderma	Breast cancer
Insomnia	Liver problems	Tubes in ears	Difficulty breathing		Hernia	Swollen ankles	Fibromyalgia	
Depression	Excessive Thirst	Chronic sore throat	Pneumonia		Stiff neck	Heart trouble	Chronic Fatigue Syndrome	
Loss of weight		Mononucleosis	Lung cancer			Poor circulation		

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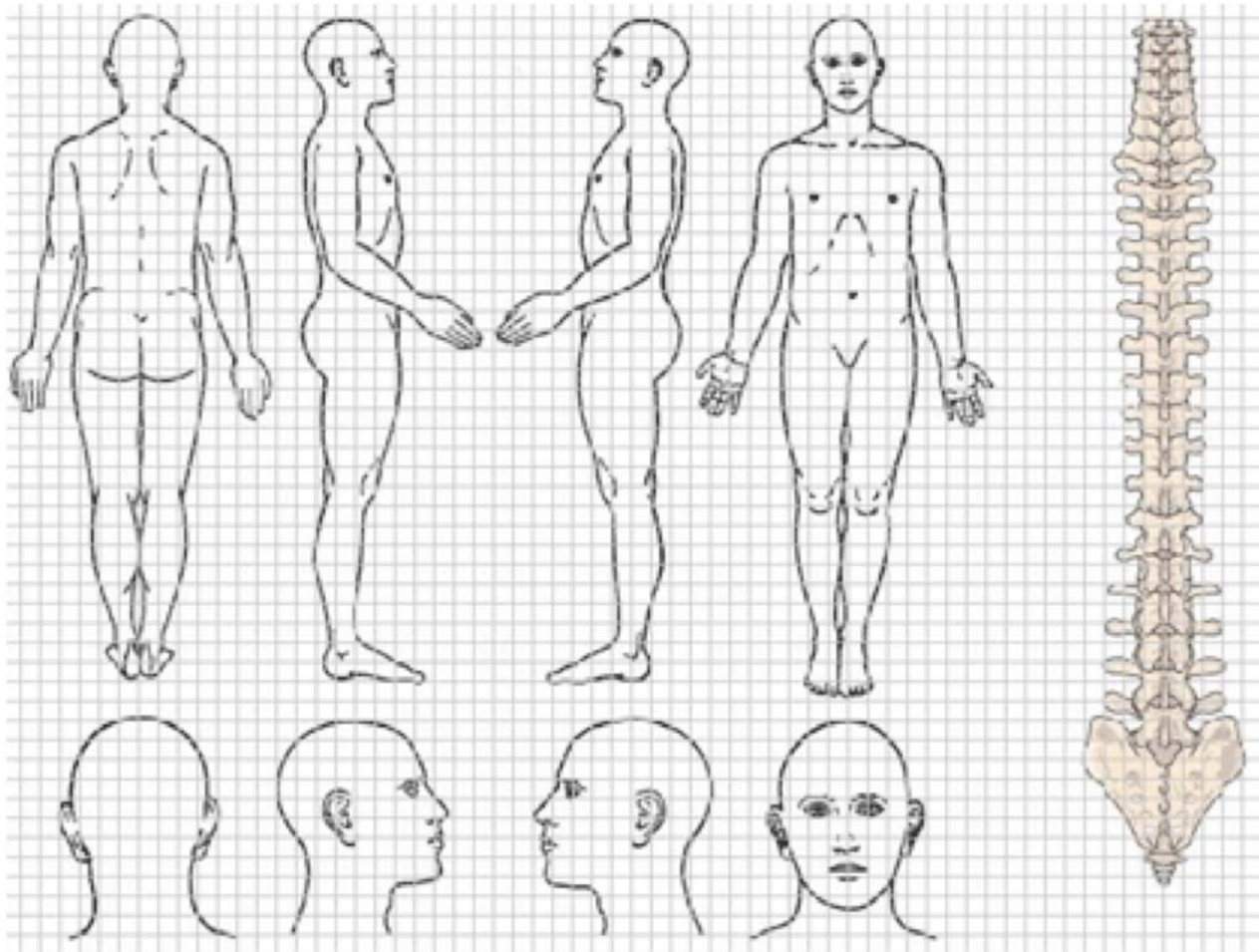
Have you had any auto accidents, sports injuries, trauma of some sort? Yes No If yes, list when and explain each incident below : i.e. rear-ended, fell off a ladder, in 2008, in college, hospitalized, no treatment, PT, chiropractic, etc.

On a scale of 0 to 10; zero meaning no pain (or symptoms) and 10 meaning you need to go to the emergency room (or worse symptoms imaginable) please write a number accordingly.

Today's pain/symptoms _____ Pain/symptoms average this week _____ Pain/symptoms at its worst _____

Do your pain/symptoms radiate/travel? Yes No If yes, where? _____

Please indicate below the area(s) that you wish to be treated. Circle or write in descriptor words for your symptoms.



Sharp
Dull
Stabbing
Ache
Throbbing
Burning
Tingling
Numbness
Shooting
Stiff
Weak

I attest I have answered all questions pertaining to my health truthfully and thoroughly.

Signature (guardian signature if under 18) _____ Date ____/____/____