# Chiropractic Patient Information Form

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| Practitioner Last Name | First Name | M.I. | License # | Phone # | Fax # |
|---|---|---|---|---|---|
| | | | | | |

***Patient to complete the following sections:***

| Patient Last Name | Patient First Name | M.I. | Gender ☐M ☐F | Age | Date of Birth (MM/DD/YYYY) / / |
|---|---|---|---|---|---|
| Insured I.D. or SSN | Insured Last Name | M.I. | First Name | | Patient Daytime Phone |
| Patient Address | City | | State | | Zip |
| Employer Name | Insurance Company | | Group Plan # or Union Local | | |
| Is illness or injury related to: ☐Work ☐Auto ☐Other | Do you have other insurance that might cover this injury/illness? ☐Yes ☐No | | If yes, please list other insurance company name: | | |

| Please list your reason(s) for this visit or your condition(s) in order of importance: | Date you first noticed: | Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), **circle** the number that best reflects your condition: ↓ **none . . . . . to . . . . . severe** ↓ | Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason: |
|---|---|---|---|
| 1 _____ | _____ | 0 1 2 3 4 5 6 7 8 9 10 | ❑0-25% ❑26-50% ❑51-75% ❑76-100% |
| 2 _____ | _____ | 0 1 2 3 4 5 6 7 8 9 10 | ❑0-25% ❑26-50% ❑51-75% ❑76-100% |
| 3 _____ | _____ | 0 1 2 3 4 5 6 7 8 9 10 | ❑0-25% ❑26-50% ❑51-75% ❑76-100% |
| 4 _____ | _____ | 0 1 2 3 4 5 6 7 8 9 10 | ❑0-25% ❑26-50% ❑51-75% ❑76-100% |

**For each of the reasons or conditions listed above, please mark how it happened:**

**1.** ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know

**2.** ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know

**3.** ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know

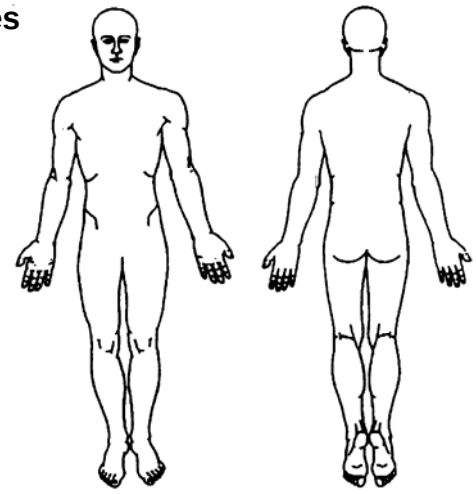
**4.** ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know

**For each reason listed above, please check if it is <u>better</u> or <u>worse</u> with any of the following:**

| | HEAT | | COLD | | REST | | ACTIVITY | | OTHER (please describe on line below) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | better | worse | better | worse | better | worse | better | worse | better | worse |
| **Reason 1** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ _____ |
| **Reason 2** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ _____ |
| **Reason 3** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ _____ |
| **Reason 4** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ _____ |

**Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:**

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/ / / Numbness



**Please check the box that best describes whether your pain or symptom(s) limit normal activities:**

| Activity | Normal | Somewhat limited | Severely limited |
|---|---|---|---|
| Lifting | ❑ | ❑ | ❑ |
| Bending | ❑ | ❑ | ❑ |
| Standing | ❑ | ❑ | ❑ |
| Walking | ❑ | ❑ | ❑ |
| Sitting | ❑ | ❑ | ❑ |
| Climbing stairs | ❑ | ❑ | ❑ |
| Running | ❑ | ❑ | ❑ |
| Resting in bed | ❑ | ❑ | ❑ |
| Intercourse | ❑ | ❑ | ❑ |
| Computer work/typing | ❑ | ❑ | ❑ |
| Normal work | ❑ | ❑ | ❑ |
| Household activities | ❑ | ❑ | ❑ |
| Recreational activities | ❑ | ❑ | ❑ |
| Other (list below) | ❑ | ❑ | ❑ |
| _____ | ❑ | ❑ | ❑ |

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# Chiropractic Patient Information Form

**Please continue …**

a. During what time of the day do you feel worse? _____

b. Do you sleep well? ❑ Yes ❑No What are your normal sleeping hours? _____to _____

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
❑ No ❑ Yes → For what condition?_____

Name of doctor/provider _____ Phone number _____

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
❑ No ❑ Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

e. Do you exercise? ❑ Yes ❑ No If yes, please describe activity _____

How many days a week? _____ How many minutes per session?_____

## Personal history

**The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.**

**Pain in body**

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

**Types of pain**

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

**Current conditions**

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

**Previously diagnosed condition/ medical history**

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ 3 or more months use of steroid medications or intravenous drugs (past or recent)

## Family history

❑ Autoimmune disorders ❑ Cancer ❑ Heart disease ❑ Mental illness
❑ Arthritis ❑ Diabetes ❑ Kidney disease ❑ Seizure disorder

***I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.***

Signature _____ Today's date:_____/_____/_____

***If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:***

Name _____Relationship _____ Today's date:_____/_____/_____