Confidential Patient Data

PATIENT INFORMATION **Today's Date:_____**

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

CellPhone:_____Alt.Phone:_____EmailAdress:_____

Social Security #:_____ Age:_____ ❑ Male ❑ Female
Marital Status:
❑ Married ❑Single ❑Divorced ❑Separated ❑ Other _____ Number of Children_____

Your Occupation_____ Your Employer:_____
❑ Full-Time ❑Part-Time ❑Retired ❑Student ❑Homemaker ❑ Disabled ❑Unemployed

Emergency Contact Name:_____ Relation to you:_____
Phone:_____
Referred to this Office by: ❑Friend/Family Member - Name?_____
❑Advertisement ❑ Social Media ❑Internet ❑Direct Marketing/Other_____

Name of Insurance Co.:_____Member#_____Group#_____

Insured's Name _____ Insured's Social Security #:_____Insured's DOB_____

Are you covered by more than one insurance company? ❑Yes ❑No If, Yes please list info below.

Name of Insurance Co _____ Member#_____Group#_____

The Reason for your visit: ❑Auto/Cycle Accident ❑Slip and Fall ❑Sports Injury
❑Home Injury ❑Pain ❑Other_____(Please describe)
Have you been or are currently being treated by a physician for any health condition(s)?
❑Yes ❑No Describe Condition_____
Date of Last Physical Exam_____
Are there any past conditions or illnesses you have that we should be aware of? ❑Yes ❑No
1._____ Date:_____
2._____ Date:_____
Has anyone in your family been treated for or any serious health conditions or illnesses? ❑Yes ❑No
(such as cancer, diabetes, hypertension, etc.?)
1._____ Relation:_____
2._____ Relation:_____
SURGICAL HISTORY:
1._____ Date:_____
2._____ Date:_____
Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No
Are you currently taking any medications? ❑Yes ❑No Are you pregnant? ❑Yes ❑No

Medication List:._____ Date of last menstrual period:_____
_____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS ❑Yes ❑No
If so WHAT KIND?_____

COMPLAINTS/SYMPTOMS

AREA OF COMPLAINT/SYMPTOM:_____
(Please list each area of complaint separately)

Approximate date of onset:_____

How did this occur?:_____

Is the pain…?(Check box that most applies)
❑ CONSTANT ❑ FREQUENT ❑ INTERMITTENT ❑ON/OFF ❑ RANDOM ❑ RECURRING

On a scale from 1-10 Please rate this complaint/symptom: **#**_____
(10 being the worst**)**

Describe your discomfort for the above listed symptom. Choose all that apply:

❑Aching	❑Deep	❑Heavy	❑Sharp	❑Throbbing
❑Annoying	❑Diffuse	❑Intolerable	❑Shock like	❑Tightness
❑Burning	❑Dull	❑Pulling	❑Stabbing	❑Tingling

Has your symptom changed since ONSET? Choose all that apply:

❑Pain has improved	❑Pain has worsened
❑Pain stayed the same	❑Symptoms have disappeared

What improves your condition? Choose all that apply:

❑Chiropractic adjustments	❑Massage	❑Prescription medication
❑Cold packs	❑Nothing	❑Rest
❑Exercise	❑Over The Counter medication	❑Stretching
❑Heat packs	❑Physical Therapy	❑Work

What aggravates your condition? Choose all that apply:

❑Almost any movement	❑Coughing/sneezing	❑Household chores	❑Running	❑Working
❑Bathing	❑Daily child or pet care	❑Lifting	❑Sitting	❑Yardwork
❑Bending	❑Driving	❑Looking over shoulder	❑Squatting	
❑Caring for family	❑Eating	❑Lying down	❑Standing	
❑Carrying	❑Falling or staying asleep	❑Pulling	❑Stress	
❑Changing positions	❑Getting in or out of car	❑Pushing	❑Stretching	
❑Climbing stairs	❑Getting out of bed	❑Reaching	❑Talking on telephone	
❑Computer use	❑Getting up from laying down	❑Reading	❑Turning	
❑Concentrating	❑Getting up from sitting	❑Repetitive motions	❑Twisting	
❑Cooking	❑Grocery shopping	❑Resting	❑Walking	

Past episodes for this complaint?
❑Yes ❑No

Past care for this complaint?
❑Yes ❑No

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