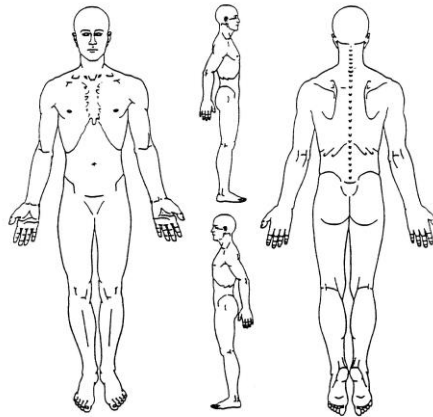


General Patient Information

Last Name _____ First Name _____ M.I. _____
 Address _____ Apt# _____
 City _____ State _____ Zip _____
 Primary Phone _____ E-mail _____
 Date of Birth _____ Age _____ Gender: Male Female
 Occupation _____ Employer _____
 Name of patient's guardian (if applicable) _____
 Are you insured by Medicare? Y N If so, do you have supplemental insurance as well? Y N
 Besides Medicare/VCP insurance, we are an out-of-network clinic, but we can submit your charges. Would you like us to do that for you? Y N
 How did you hear about us? _____
 Have you been to a Chiropractic Physician before? Y N
 If yes, please explain _____
 Marital Status:
 Single Married Divorced/Separated Widowed
 Height ____ Ft. ____ In. Weight ____ Lbs.
 Patient or Parent (Under 18 YOA) Signature: _____ Date: _____

What brings you in to the clinic today?

Mark the area of complaint and/or symptoms in the diagram below:



What is your chief (#1) complaint? _____

Is the complaint related to an auto accident? Yes No

Is the complaint related to a work injury? Yes No

What do you think caused this complaint?

When did the symptoms begin? _____

Have you had previous episodes of this complaint? _____

Describe the quality of your complaint (circle all that apply):

Sharp Pain Dull Pain Ache Weakness Throbbing Numbness Tingling
Shooting Burning Tightness/Stiffness Other: _____

Describe the frequency of your complaint:

Constant (76% or greater) Frequent (51-75%) Occasional (26 – 50%)
Intermittent (25% or less)

Are you experiencing any of the following symptoms?

Pain wake you up at night N Y, Explain: _____
Unexpected weight loss or gain N Y, Explain: _____
Worst headaches of your life N Y, Explain: _____
Vomiting and/or blood in your stool N Y, Explain: _____
Loss of bladder or bowel control N Y, Explain: _____

Indicate the intensity of your pain at its best (b)/worst (w)/average (a) level

No Pain 1 2 3 4 5 6 7 8 9 10 *Most pain*

How are your symptoms changing?

Getting Better Not Changing Getting Worse

Symptoms are worse in the:

Morning Afternoon Night Same all day

How much does the pain interfere with your daily living activities?

None A little bit Moderately Quite a bit Extremely

What daily living activities are difficult because of the complaint?

Does the complaint radiate or travel to any other areas in your body? Yes No

If so, where? _____

Do any of these make your problem better (b) or worse (w)?

Lying down Walking Standing Sitting
Movement/Exercise Inactivity Bending Coughing/Sneezing

Who else have you seen for this complaint? _____

Have you done anything for home treatment? (Ice/heat/NSAID) _____

List any other complaints in order of severity:

1. _____
2. _____
3. _____

Health History

Are you pregnant? N Y If so how far along are you? _____

Is this your first pregnancy? Y N If not how many have you had? ____

How were your children delivered? Vaginally____ Caesarian____ V-BAC____

Have you had any complications during delivery? Y N If yes, please explain:

Please list number of Children: ____ Miscarriages: ____ Number of abortions: ____

Name of current pre-natal practitioner (Midwife, OB/GYN): _____

Name of current pre-natal facility: _____

Is your baby (circle if known): Vertex Breech Transverse

Please list any complications you may be experiencing during this pregnancy:

List any medications/vitamins/supplements you are currently taking:

Number of caffeinated drinks/week? _____ Alcohol drinks/week? _____

Smoking status: Current smoker Never Quit __ years ago

List any confirmed or suspected allergies you have:

In the last 5 years have you had any of the following?

Surgery/Hospitalizations: _____

Serious Illnesses: _____

Traumatic injuries: _____

How many hours of sleep are you currently getting per night? ____ Is this normal for you? ____

Do you exercise? Y N

If so, WHAT and HOW OFTEN? _____

Would you consider your current diet to be: Poor Average Clean

Do you have a history or family history of any of the following illnesses/diseases? (Circle S for self, M for mother's side and F for father's side)

Heart Disease	S	M	F	Allergies/Asthma	S	M	F
Hypertension	S	M	F	Cancer	S	M	F
Stroke	S	M	F	Migraines	S	M	F
Arthritis	S	M	F	Back Problems	S	M	F
Diabetes	S	M	F	Lung Disease	S	M	F

Systems Review

Besides the complaint(s) you're here for, do you currently or have you ever had any of the following? If yes please explain.

Significant *skeletal* complaints such as: fractures, osteoporosis, arthritis, bone pain/bruises, disc herniation, etc.

Significant *muscular* complaints such as: weakness, sprains/strains, lumps, etc.

Significant *neurological* complaints such as: seizures, strokes, numbness/tingling, burning, weakness, poor coordination, headaches, etc.

Significant *skin* complaints such as: rashes, sores, bumps, concerning moles, bruising, itching, hair loss, etc.

Significant *pulmonary* complaints such as: asthma, shortness of breath, wheezing, coughing up blood, difficulty breathing, pneumonia, persistent cough, etc.

Significant *cardiovascular* complaints such as: heart murmurs, heart attacks, heart skipping a beat, chest pain, rapid pulse, high/low blood pressure, varicose veins, foot/ankle swelling, leg cramping, aneurisms, hot/cold feet or hands, etc.

Significant *gastrointestinal* complaints such as: gastric reflux, difficulty eating/drinking, vomiting, bloating, diarrhea, constipation, blood/abnormal stool, hemorrhoids, liver disease, gall bladder disease, etc.

Significant *genitourinary* complaints such as: difficulty urinating, dribbling, bed-wetting, kidney stones, infections, painful intercourse, enlarged prostate, menstrual problems etc.

Significant *psychological* complaints such as: depression, overwhelming anxiety/stress, thoughts of harming yourself/others, mood swings, PTSD, etc.

Significant *eye* complaints such as: poor vision, redness, excessive watering or crustiness, pain behind the eye,

floaters, double vision, light sensitivity, etc.

Significant *ear* complaints such as: loss of hearing, ringing in the ears, feelings of fullness, infection, clear fluid drainage, etc.

Significant *nose* complaints such as: excessive drainage, bleeding, congestion, etc.

Significant *oral* complaints such as: jaw pain, jaw clicking, mouth sores, sore throat, difficulty swallowing, tooth loss, bleeding gums, etc.

Do you have any other health complaints that were not asked about?

Dependency on drugs or alcohol?	Y	N
Do you feel safe at home?	Y	N