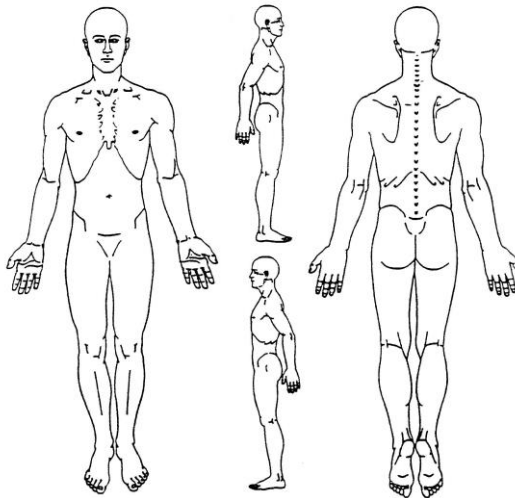


General Patient Information

Last Name _____ First Name _____ M.I. _____
 Patient's Guardian Name _____
 Address _____ Apt# _____
 City _____ State _____ Zip _____
 Primary Phone _____ E-mail _____
 Date of Birth _____ Age _____ Gender: Male Female
 Health Care Plan Provider (if applicable) _____
 How did you hear about us? _____
 Have you been to a Chiropractic Physician before? Y_ N_
 If yes, please explain _____
 Patient/Guardian 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 complaint? _____

Is the complaint related to an auto accident? Yes No

Is the complaint related to a work injury? Yes No

Describe the circumstances of your complaint(s):

When did the symptoms begin? _____

Was there a triggering event? _____

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

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

Describe the frequency of your complaint:

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

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?

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. _____

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

Pregnancy

Please check any areas that applied to the patient's mother during her pregnancy:

- | | | |
|---|--|--|
| <input type="checkbox"/> Complications | <input type="checkbox"/> Vitamins/Minerals | <input type="checkbox"/> Attitude - Mostly Happy |
| <input type="checkbox"/> Excessive Weight Loss | <input type="checkbox"/> Medications | <input type="checkbox"/> Attitude - Mostly Depressed |
| <input type="checkbox"/> Excessive Weight Gain | <input type="checkbox"/> Any diagnosed Illnesses | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Premature Contractions | <input type="checkbox"/> Immunization | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Prenatal Classes | <input type="checkbox"/> Caffeine (Cola/Coffee/Tea) |
| <input type="checkbox"/> Toxic Exposures | <input type="checkbox"/> Chiropractic Care | |
| <input type="checkbox"/> Allergic Reactions | <input type="checkbox"/> Prenatal Care | |
| <input type="checkbox"/> Mental Trauma | <input type="checkbox"/> Carried to Full Term | |
| <input type="checkbox"/> Physical Injury | | |

Labor and Delivery

- | | | |
|--|---|---|
| <input type="checkbox"/> Home Birth | <input type="checkbox"/> Forceps | <input type="checkbox"/> Medications (list below) |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Vacuum Extraction | 1. _____ |
| <input type="checkbox"/> Greater than 12 hours | <input type="checkbox"/> Fetal Monitor Used | 2. _____ |
| <input type="checkbox"/> Less than 5 hours | <input type="checkbox"/> Caesarian | 3. _____ |
| <input type="checkbox"/> Complications | <input type="checkbox"/> Premature Delivery | 4. _____ |
| Other _____ | | |

Perinatal History-if known please indicate

The duration of the pregnancy was _____ weeks.
 The APGAR score at birth was _____. The APGAR score at five minutes was _____.
 The length at birth was _____. The birth weight was _____.

Please check any problems the patient had at birth:

- Breathing Nursing Choking Jaundice Coloring Sleeping
 Crying Other (please explain) _____

Please check if any item(s) applied to the patient at birth

- Medication Surgery Artificial Feeding Erythromycin Vitamin K
 Circumcision Other (please explain) _____

Please check if the patient has received any of the following items:

Breast milk Commercial Formula Cow's milk Goat's Milk
 Solid Food Sweets Fruit Juice Vegetable Juice
 Medications Other _____

Immunizations

Please list immunizations, date received, and any reactions:

Note foreign travel: _____

Signature of parent/guardian: _____ **Date:** _____