AccessHealth
CHIROPRACTIC CENTER, PC

1517 OLD APEX ROAD SUITE 118 CARY, NC 27513
(919) 377-0351 WWW.ACCESSHEALTHCHIRO.COM

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? _____

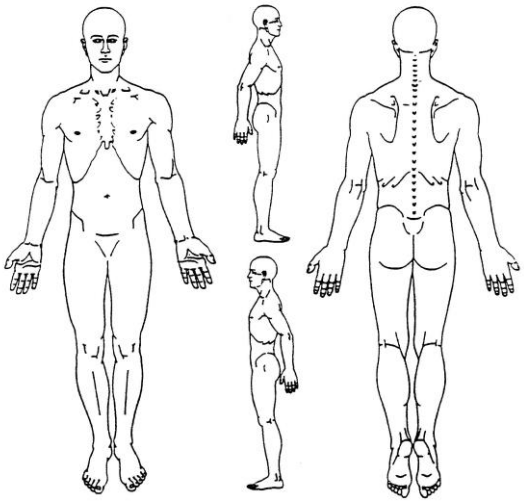
Have you been to a Chiropractic Physician before? Y__ N__

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

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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

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Pregnancy

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

_____Complications
- ☐ Excessive Weight Loss
- ☐ Excessive Weight Gain
- ☐ Bleeding
- ☐ Premature Contractions
- ☐ Back Pain
- ☐ Toxic Exposures
- ☐ Allergic Reactions
- ☐ Mental Trauma
- ☐ Physical Injury

_____Vitamins/Minerals
_____Medications
_____Any diagnosed Illnesses
_____Hospitalization
_____Immunization
_____Prenatal Classes
_____Chiropractic Care
_____Prenatal Care
_____Carried to Full Term

_____Attitude – Mostly Happy
_____Attitude – Mostly Depressed
_____ Recreational drugs
_____ Smoking
_____ Alcohol
_____ Caffeine (Cola/Coffee/Tea)

Labor and Delivery

_____Home Birth
_____Hospital
_____Greater than 12 hours
_____Less than 5 hours
_____Complications

_____Forceps
_____Vacuum Extraction
_____Fetal Monitor Used
_____Caesarian
_____Premature Delivery

_____Medications (list below)
1. _____
2. _____
3. _____
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 _____Erythromyocin _____Vitamin K

_____Circumcision _____Other (please explain) _____

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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:_____