Today's Date: ____/____/_____

PATIENT INFORMATION

Name: (First MI Last) _____

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

Date of Birth: _____ Gender: Male Female Height & Weight_____

Mobile: _____ Home (if applicable): _____

Email: _____

*Referred By: (Name) _____

Family Friend Co-Worker Doctor Other: _____

Emergency Contact Name:_____Phone Number:_____

FINANCIAL INFORMATION

Is today's visit the result of an accident? No Auto Work Other: _____

Will we be working with insurance? Yes No

Primary Ins: _____

Primary Ins Holders Name & Date of Birth:_____

Secondary Ins (if applicable): _____

Secondary Ins Holders Name & Date of Birth:_____

Address of Policy Holder:_____

Where would you like statements sent?

☐ Self ☐ Other (Details below)

Name: _____ Address:
_____ Phone: _____

PRIMARY CARE

Primary Care Physician: _____

Clinic Name (If known): _____

Have you seen them within the last 12 months? Yes No

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: _____ Secondary Complaints: _____

_____ _____

_____ _____

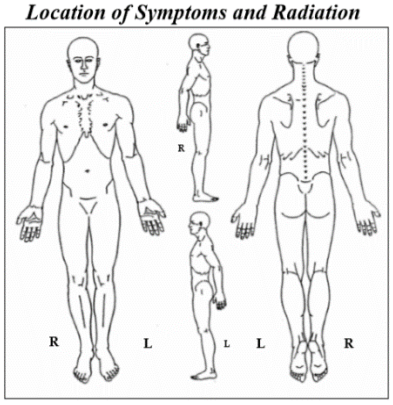
When did it start? ____/____/_____ What happened? _____

_____

Which daily activities are being affected by this condition? _____

_____

Location of Symptoms and Radiation



P __ Pain T__ Tender
N __ Numb H__ Hypoesthesia
S __ Spasm

Grade Intensity/Severity:

☐ None (0/10)
☐ Mild (1-2/10)
☐ Mild-Moderate (2-4/10)
☐ Moderate (4-6/10)
☐ Moderate-Severe (6-8/10)
☐ Severe (8-10/10)

Frequency:

☐ Off & On
☐ Constant

MAJOR COMPLAINT

Quality:

☐ Sharp
☐ Stabbing
☐ Burning
☐ Achy
☐ Dull
☐ Stiff & Sore
☐ Other:

_____

Does it radiate?

☐ No ☐ Yes (Please indicate on drawing)

Improves with:

☐ Ice
☐ Heat
☐ Movement
☐ Stretching
☐ OTC Medications:

_____

☐ Other:

_____

Worsens with:

☐ Sitting
☐ Standing/Walking
☐ Lying Down/Sleeping
☐ Overuse/Lifting
☐ Other:_____

Previous Treatment:

☐ None
☐ Chiropractor
☐ Physical Therapy
☐ Medical Doctor
☐ ER/Urgent Care
☐ Orthopedic
☐ Other (including injections):

_____

Previous Diagnostic Testing:

☐ None
☐ X-rays
☐ MRI
☐ CT
☐ Other:

_____

_____

*Women: Are you pregnant?

☐ No
☐ Yes
- Due date: ___/___/____

PAST AND SOCIAL HISTORY

PAST MEDICAL HISTORY Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder (Type) _____
  Blood Clots
- ☐ Cancer (Type) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____
  _____
  _____

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ **Falls**
- ☐ Other: _____

Hospitalizations: (Non-surgical with Date)

_____
_____

Current Medications including OTC (can provide copy if easier):

_____
_____
_____
_____
_____
_____
_____

Surgeries: (If yes, provide type & surgery date)

- ☐ Cancer _____
- ☐ Orthopedic_____
- ☐ Shoulder – R / L _____
  Elbow/Forearm – R / L _____
  Wrist/Hand – R / L _____
- ☐ Hip – R / L _____
  Knee – R / L _____
- ☐ Ankle/Foot – R / L _____
- ☐ Spinal Surgery_____
- ☐ Neck: _____
- ☐ Back: _____
- ☐ Other: _____
  _____
  _____

Medical History Comments:

_____
_____
_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

(If none leave blank)

Constitutional:
- ☐ Fever
- ☐ Fatigue
- ☐ Other:

Musculoskeletal:
- ☐ Joint pain/stiffness/swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones
- ☐ Others:

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Peripheral Neuropathy

Psychiatric:
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other:

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other:

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other:

Cardiovascular and Heart:
- ☐ Chest Pain/ Tightness
- ☐ Rapid or Heartbeat changes
- ☐ Swelling of Hands, Ankles, or Feet

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other:

Eyes and Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other:

Head, Ears, Nose and Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear- ache/ringing/drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other:

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other:

Hematologic and Lymphatic:
- ☐ Excessive thirst or urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other:

I**ntegumentary:** (skin, Nails, and Breasts)
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump or Discharge
- ☐ Other:

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other