COMPREHENSIVE
CHIROPRACTIC
CENTER

Patient Information

Patient Full Name:_____ Date:___/___/___

Mailing Address:_____ City:_____ State:___ Zip:____

Phone:_____cell/home (circle)__Email:_____

Date of Birth: _____/____/_____ Sex: M / F Married: Y / N Spouse's Name:_____

Height:_____feet_____inches Weight:_____

Status (circle one): Employed FT Student PT Student

Occupation:_____Employer:_____

Emergency Contact:_____Relationship:_____Phone:_____

Current Health History

Primary Complaint: _____

Date of Onset: _____Have you had this problem before? Y / N

What caused the pain? _____

What makes the pain better? _____

What makes the pain worse? _____

Does the pain travel/radiate to any other areas? _____

Has this condition affected your quality of sleep or ability to sleep? Y / N

Is there a time of day that the pain/discomfort is worse? _____

Does this condition interfere with any of your daily activities? _____

Have you missed any work due to this injury? Y / N If yes, Explain: _____

Have you received professional treatment for this condition? Y / N

If Yes, Explain:_____

Have you tried self-treatment or taken any medication (over the counter or prescription): Y / N

If Yes, Explain:_____

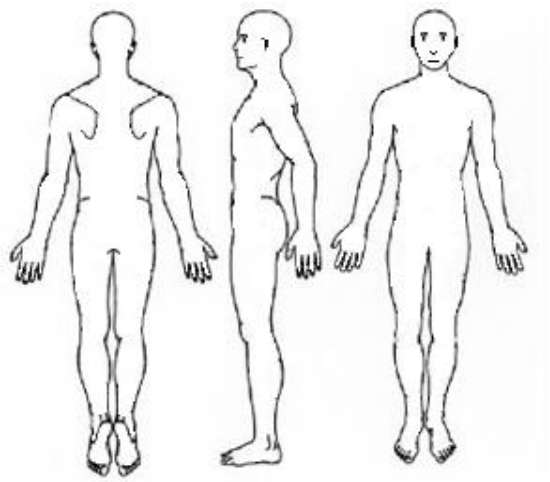
Have you had any imaging (X-ray, MRI, CT, Diagnostic Ultrasound, etc.) for your current complaint? Y / N If Yes, please state type, date, and place: _____

Circle the word(s) that describe the pain:

Aching Burning Tightness Dull Sharp Stabbing Throbbing Weakness Numbness Tingling Tension Stiffness

Place an "**X**" on areas of complaint.

Use letter to describe type of pain: **A** = Ache, **B** = Burn, **D** = Dull, **S** = Sharp, **N** = Numbness, **T** = Tingling



Pain Scale:

0 1 2 3 4 5 6 7 8 9 10

(No pain Mild Moderate Severe)

Pain currently:_____, Pain at its worst:_____

Personal Health History

Family/Primary Physician Name:_____Date of Last Physical Exam:_____

Physician place of work:_____Physician State:_____Zip:_____

List any health conditions you have been diagnosed and/or treated for in the last year:

_____

_____

Have you had previous chiropractic care? Y / N

Date of last chiropractic visit:_____Name of Practice:_____

Are you pregnant, or have you had any signs of pregnancy (female only)? Y / N

Current Medications:

_____

_____

Please list current vitamins, minerals, supplements, or herbs:

_____

_____

Past Health History

Have you had any broken bones? Y / N If Yes, Explain:_____

Have you had any major sprains/strains? Y / N

If Yes, Explain:_____

Have you been hospitalized? Y / N

If Yes, Explain:_____

Have you had surgery? Y / N

If Yes, Explain:_____

Have you been in an auto accident? Y / N If Yes, did you get treatment?_____

Have you ever had a stroke or been treated for stroke symptoms? Y / N If Yes, Explain:

_____

Any abnormal lab tests in the last year? Y / N If Yes, Explain:_____

List any allergies (food, drug, seasonal): _____

Family Health History

Please list diagnosed health conditions and untimely deaths of your blood-related family members: (Example: diabetes, cancer, heart disease, respiratory disease, high cholesterol, etc.)

_____

Social History

Recreational Activities (Hobbies):_____

Do you exercise? Y / N If Yes, how many times per week?_____What type?_____

Do you smoke? Y / N If Yes, how many packs per day?_____

Do you consume alcohol? Y / N If Yes, how many drinks per week?_____

Do you use recreational drugs? If Yes, Explain:_____

How many hours of sleep do you get a night?_____

Do you find work to be stressful? Y / N

If Yes, Explain:_____

What activities can you not perform currently that you would like to be able to do once treatment is finished? (Example: run without knee pain, sit down without pain, travel without pain, etc.)

_____