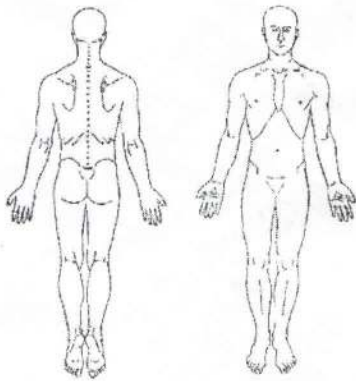




PATIENT INFORMATION FORM

Name _____	Address _____	City _____
State _____ Zip _____	Home Phone _____	Work Phone _____ Cell Phone _____
E-mail Address _____	☐ Male ☐ Female	Age _____ Birth date _____
Occupation _____	Patient Employer/School _____	
Employer/School Address _____	Employer/School Phone _____	
Marital Status ☐ W ☐ S ☐ M ☐ D	Spouse's Name _____	
Spouse's Employer _____	Spouse's Work or Cell Phone _____	
Whom may we thank for referring you? _____		

PATIENT CONDITION

Reason for visit _____	
When did your symptoms appear? _____	
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown	
Mark an X on the picture where you continue to have pain, numbness, or tingling.	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)	
type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning	
☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____	
How often do you have this pain? _____	
Is it constant or does it come and go? _____	
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation	
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down.	

HEALTH HISTORY

What treatment have you already received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None		
☐ Other _____		
Name and address of other doctor(s) who have treated you for this condition _____		
Date of last		
Physical Exam _____	Spinal X-Ray _____	Blood Test _____
Spinal Exam _____	Chest X-Ray _____	Urine Test _____
Dental X-Ray _____	MRI, CT-Scan, Bone Scan _____	

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

☐ Yes ☐ No AIDS/HIV	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Measles	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Alcoholism	☐ Yes ☐ No Emphysema	☐ Yes ☐ No Migraine Headache	☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Allergy Shots	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Miscarriage	☐ Yes ☐ No Stroke
☐ Yes ☐ No Anemia	☐ Yes ☐ No Fractures	☐ Yes ☐ No Mononucleosis	☐ Yes ☐ No STD
☐ Yes ☐ No Anorexia	☐ Yes ☐ No Glaucoma	☐ Yes ☐ No Multiple Sclerosis	☐ Yes ☐ No Suicide Attempt
☐ Yes ☐ No Appendicitis	☐ Yes ☐ No Goiter	☐ Yes ☐ No Mumps	☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Arthritis	☐ Yes ☐ No Gonorrhea	☐ Yes ☐ No Osteoporosis	☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Asthma	☐ Yes ☐ No Gout	☐ Yes ☐ No Pacemaker	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Bleeding Disorders	☐ Yes ☐ No Heart Disease	☐ Yes ☐ No Parkinson's Disease	☐ Yes ☐ No Tumors, Growths
☐ Yes ☐ No Breast Lump	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Pinched Nerve	☐ Yes ☐ No Typhoid Fever
☐ Yes ☐ No Bronchitis	☐ Yes ☐ No Hernia	☐ Yes ☐ No Pneumonia	☐ Yes ☐ No Ulcers
☐ Yes ☐ No Bulimia	☐ Yes ☐ No Herniated Disk	☐ Yes ☐ No Polio	☐ Yes ☐ No Vaginal Infections
☐ Yes ☐ No Cancer	☐ Yes ☐ No Herpes	☐ Yes ☐ No Prostate Problem	☐ Yes ☐ No Whooping Cough
☐ Yes ☐ No Cataracts	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Prosthesis	Other _____
☐ Yes ☐ No Chemical Dependency	☐ Yes ☐ No High Cholesterol	☐ Yes ☐ No Psychiatric Care	
☐ Yes ☐ No Chicken Pox	☐ Yes ☐ No Kidney Disease	☐ Yes ☐ No Rheumatoid Arthritis	
	☐ Yes ☐ No Liver Disease		

Would you like to:

☐ Have more energy	☐ Feel more motivated	☐ Be free of pain
☐ Be stronger	☐ Be more organized	☐ Sleep better
☐ Have more endurance	☐ Think more clearly and be more focused	☐ Have agreeable breath
☐ Increase your sex drive	☐ Improve memory	☐ Have agreeable body odor
☐ Be thinner	☐ Do better in tests in school	☐ Have stronger teeth
☐ Be more muscular	☐ Not be dependent on the over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.	☐ Get less cold and flus
☐ Improve your complexion	☐ Stop using laxatives or stool softeners	☐ Get rid of your allergies
☐ Have healthier hair		☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)
☐ Be less moody		Other _____
☐ Be less depressed		
☐ Be less indecisive		

Exercise

- ☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

- ☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

- ☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Weeks _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Date of onset of last menstrual period _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins/ Herbs/ Minerals

_____	_____	_____
_____	_____	_____
_____	_____	_____