**PATIENT INFORMATION**

Patient Name: ____________________

Birth Date: __________ Sex: M F

Married Single Divorced Widowed Do you live alone? Yes No

Address: ____________________

Phone: (cell): __________ (home): __________

Emergency Contact: __________ Phone: __________

Are you employed? Yes No Employer: __________

Physician: __________ Location: __________

Physician Phone Number: __________

**INSURANCE**

**PRIMARY INSURANCE:** Name of Insurance Company: __________

Responsible Party/Policy Holder: __________ DOB: __________

**SECONDARY INSURANCE:** Name of Insurance Company: __________

Responsible Party/Policy Holder: __________ DOB:__________

**WORK OR AUTO ACCIDENT:** Is this visit due to a work or auto accident? Yes No
(If you answered no skip to next page)

Carrier/Insured Name: __________ Claim Number: __________

Adjustor Name: __________ Phone: __________

Name: ____________________ DOB: __________

## PAST MEDICAL HISTORY

Serious Injuries (describe any significant injuries you have had in your life):

____________________________________ year __________

____________________________________ year __________ Check here if none ☐

Surgeries (list any previous operations you have had):

____________________________________ year __________

____________________________________ year __________

____________________________________ year __________ Check here if none ☐

Medical Conditions: ____________________________________________________________

**Do you have a history of cancer?** Yes No What type? ______________________

Please list any allergies: ______________________________________________________

Do you have any excessive bruising or bleeding? Yes No

Have you had steroids in the last 12 months? Yes No

**MEDICATIONS:** Check here if none: ☐ Check here for attached list: ☐

Medication name: ______________________ Reason for prescription: ______________________

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Name: ____________________ DOB: __________

## TELL US ABOUT YOUR SYMPTOMS:

Main complaint today: ______________________

Have you had back/neck problems before this pain episode? Yes No

Have you had previous back or neck surgery?
Yes No
If so, where ____________________

When did symptoms begin? _______________

How did they begin? ______________________

Is your pain a result of injury? Yes No

Is there a lawsuit pending on this problem?
Yes No

What tests have you had? X-ray ☐ MRI ☐
CT scan ☐ If so, where? _________________

Do you have pain that radiates into the arm or leg? Yes No

Have you had any changes in bowel, bladder, or sexual functions? Yes No

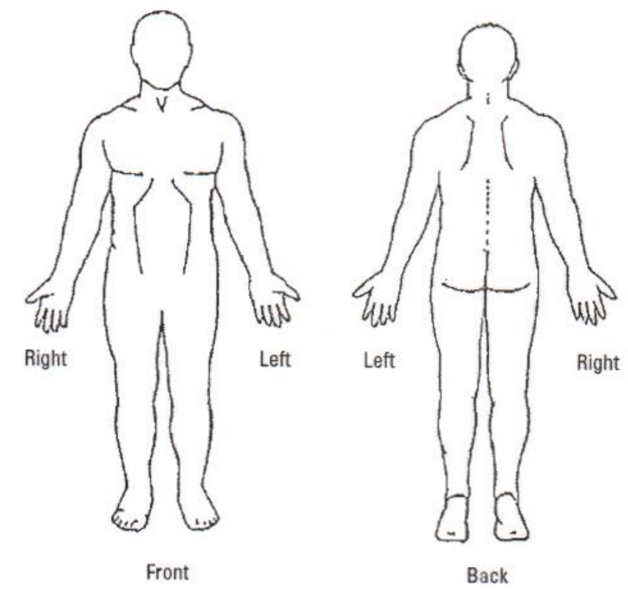
Do you have any pain, weakness, numbness, or tingling in your arm or leg? Yes No

What treatments have you had for this problem?
Chiro ☐ PT ☐ Primary Dr. ☐ Surgery ☐
Injections ☐ Other ☐
Did these treatments help? Yes No

Circle your pain level: 0 to 10, 10 being the worst imaginable pain.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| **No Pain** | | **Mild, Annoying**<br>Pain is present but does not limit activity | | **Nagging, Uncomfortable, Troublesome**<br>Can do most activities with rest periods | | **Miserable, Distressing**<br>Unable to do some activites because of pain | | **Intense, Dreadful, Horrible**<br>Unable to do most activities because of pain | | **Worst Pain Possible**<br>Unable to do most activities because of pain |

Circle any areas where you have pain




What makes your symptoms worse?

________________________________________

What makes your symptoms better?

________________________________________

Name: ____________________ DOB: __________

## GENERAL:

| Item | Yes | No |
|---|---|---|
| Unexplained fever/chills | Yes ☐ | No ☐ |
| Night sweats | Yes ☐ | No ☐ |
| Excessive fatigue | Yes ☐ | No ☐ |
| Sleeping problems | Yes ☐ | No ☐ |
| Weight gain/loss | Yes ☐ | No ☐ |
| Difficulty swallowing | Yes ☐ | No ☐ |
| Vision changes | Yes ☐ | No ☐ |

## HEART (CARDIOVASCULAR):

| Item | Yes | No |
|---|---|---|
| High blood pressure | Yes ☐ | No ☐ |
| Chest pain/angina | Yes ☐ | No ☐ |
| Heart racing/skipping | Yes ☐ | No ☐ |
| Heart attack/failure | Yes ☐ | No ☐ |
| Pacemaker | Yes ☐ | No ☐ |
| Ankle swelling | Yes ☐ | No ☐ |

## LUNGS (PULMONARY):

| Item | Yes | No |
|---|---|---|
| Shortness of breath | Yes ☐ | No ☐ |
| Chronic cough | Yes ☐ | No ☐ |
| Wheezing | Yes ☐ | No ☐ |

## STOMACH (GASTROINTESTINAL):

| Item | Yes | No |
|---|---|---|
| Heartburn/indigestion | Yes ☐ | No ☐ |
| Nausea/vomiting | Yes ☐ | No ☐ |
| Vomiting blood | Yes ☐ | No ☐ |
| Change in bowel habits | Yes ☐ | No ☐ |
| Change in stool color | Yes ☐ | No ☐ |
| Rectal bleeding | Yes ☐ | No ☐ |
| Colon polyps | Yes ☐ | No ☐ |
| Blood in stool | Yes ☐ | No ☐ |
| Jaundice/hepatitis | Yes ☐ | No ☐ |
| Ulcers | Yes ☐ | No ☐ |
| Recurrent abdominal pain | Yes ☐ | No ☐ |

## MUSCLES/JOINTS:

| Item | Yes | No |
|---|---|---|
| Swollen/inflamed joints | Yes ☐ | No ☐ |
| History of gout | Yes ☐ | No ☐ |
| Artificial joints | Yes ☐ | No ☐ |

## KIDNEYS/URINARY:

| Item | Yes | No |
|---|---|---|
| Blood in urine | Yes ☐ | No ☐ |
| Kidney stones | Yes ☐ | No ☐ |
| Decreased urine stream | Yes ☐ | No ☐ |
| Hesitancy with urine | Yes ☐ | No ☐ |
| Flank/side pain | Yes ☐ | No ☐ |
| Burning with urination | Yes ☐ | No ☐ |
| Urinary urgency/frequency | Yes ☐ | No ☐ |
| Kidney/bladder infections | Yes ☐ | No ☐ |

## SKIN:

| Item | Yes | No |
|---|---|---|
| Changes in moles | Yes ☐ | No ☐ |
| Skin problems | Yes ☐ | No ☐ |

## PSYCHIATRIC:

| Item | Yes | No |
|---|---|---|
| Psychiatric problems | Yes ☐ | No ☐ |
| Suicidal thoughts | Yes ☐ | No ☐ |

## GLANDS/HORMONE (ENDOCRINE):

| Item | Yes | No |
|---|---|---|
| Changes in facial/body hair | Yes ☐ | No ☐ |
| Increase in hat/glove size | Yes ☐ | No ☐ |
| Thyroid problems | Yes ☐ | No ☐ |
| Diabetes | Yes ☐ | No ☐ |

## HEAD/BRAIN (NEUROLOGIC):

| Item | Yes | No |
|---|---|---|
| Headache | Yes ☐ | No ☐ |
| Fainting | Yes ☐ | No ☐ |
| Seizures/epilepsy | Yes ☐ | No ☐ |
| Memory loss | Yes ☐ | No ☐ |
| Speech difficulty | Yes ☐ | No ☐ |
| Loss of smell | Yes ☐ | No ☐ |
| Facial numbness/weakness | Yes ☐ | No ☐ |
| Extremity numbness/weakness | Yes ☐ | No ☐ |
| Muscle cramping/twitching | Yes ☐ | No ☐ |
| Dizziness/vertigo | Yes ☐ | No ☐ |
| Imbalance | Yes ☐ | No ☐ |
| Incoordination | Yes ☐ | No ☐ |
| Tremors/shaking | Yes ☐ | No ☐ |

Name: ____________________ DOB: __________

**BLOOD (HEMATOLOGIC):**

| | | |
|---|---|---|
| Enlarged lymph nodes | Yes ☐ | No ☐ |
| Abnormal blood cells | Yes ☐ | No ☐ |
| Blood transfusions | Yes ☐ | No ☐ |

**VEINS (VASCULAR):**

| | | |
|---|---|---|
| Leg pain with walking/rest | Yes ☐ | No ☐ |
| Blood clots in legs | Yes ☐ | No ☐ |
| Aortic aneurysm | Yes ☐ | No ☐ |
| Chronic leg ulcers | Yes ☐ | No ☐ |

How often do you exercise? Never Weekly Daily Type of exercise: ____________________

Have you ever smoked/chewed tobacco? Yes No If yes, for how long? ________________

Have you recently stopped tobacco products? Yes No If yes, when? ____________________

Do you drink alcohol? Yes No If yes, how much? ____________________

Do you have a history of substance abuse? Yes No

Do you have any other concerns today? ________________________________________________

I hereby authorize this facility to examine and treat me or my dependent child and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for this injury or illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy to be paid directly to this facility. I understand this information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental health disorders, and/or HIV serostatus. I understand that I am responsible for payment of any charges incurred. I accept this responsibility regardless of any reimbursement or coverage. In the case of Medicare, I am responsible for payment of any charges not paid by Medicare.

Patient Signature ________________________________________ Date ____________________

Reviewed by ____________________________________________ Date ____________________