



ABOUT YOU:

Name _____ Nickname _____ Today's Date _____

Male Female Date of Birth ___/___/___ Age ___ Height ___ Weight ___ SS# _____

Marital Status: Single Married Divorced Widowed Separated

Education: # of years completed: _____ Full-time student Part-time student Non student

Home Address: _____

Street Address/P.O. Box

City

State

ZIP Code

Home Phone _____ Work Phone _____ E-mail Address _____

How did you hear about us? Phone Book Office Sign Provider Directory Dr. _____

Health Fair/Screening A Patient: _____ Your Staff Member: _____

Other: _____

Employed: Fulltime Part time **Job Satisfaction:** Unsatisfied Satisfied Very Satisfied

Work Status: Working without restrictions Working with restrictions Not working/off since _____

Employer's Business Name _____ Years Employed _____

Occupation _____ Job Description _____

HOBBIES/INTERESTS _____

EMERGENCY CONTACT:

Name: _____

Phone: _____

Relationship: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Phone: _____

What type of injury are we seeing you for? Auto Work Sports Injury Other: _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition Improving Unchanged Getting worse

Is this condition interfering with your Work Sleep Daily Routine Other: _____

Other doctors or therapists who have treated THIS condition: _____

What do you think caused this condition? _____

INSURANCE INFORMATION: I will be paying for the services myself.

Please bill: Auto Insurance Health Insurance Worker's Compensation

Other: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Subscriber/Member #: _____ Group #: _____

Subscriber's Name: _____ Relationship: _____ Subscriber's Date of Birth: ___/___/___

Subscriber's Employer: _____

ATTORNEY'S NAME: _____ Phone: _____ Date Retained: _____

REVIEW OF SYSTEMS (Check only the ones you **currently have** or **have had** in the past.):

	Current	Past
GENERAL		
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>

SKIN		
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>

HEAD		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam: _____		
Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>

EARS		
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>

NOSE		
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>

MOUTH		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>

	Current	Past
THROAT		
Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>

NECK		
Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Masses	<input type="checkbox"/>	<input type="checkbox"/>

BREASTS		
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>
Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>

LUNGS		
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Blood	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>

HEART		
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>
Red Spots	<input type="checkbox"/>	<input type="checkbox"/>

	Current	Past
GASTROINTESTINAL		
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Black Stools	<input type="checkbox"/>	<input type="checkbox"/>

GENTOURINARY		
Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Straining	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Stones	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Urine Color _____		
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGIC		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Location _____		
Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Difficult Speech	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>

	Current	Past
ENDOCRINE		
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL		
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Twitching	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC		
Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
Insecurity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Troubled Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Undecidedness	<input type="checkbox"/>	<input type="checkbox"/>
Timid	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependent	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNIZATION/ VACCINATION		
DPT	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES ONLY

Do you have:

Breast Lumps or Pain

Problems Getting Pregnant

Vaginal Discharge

Tubal Infections

Hot Flashes

Menstrual Problems

Menstrual Cramps

Abnormal Bleeding

Spotting Between Periods

Irregular Periods

Duration of Cycle _____

Duration of Flow _____

Menstrual Flow:

Heavy Moderate Light

Age Periods Began: _____

Pregnancies _____

Births _____

Miscarriages or Abortions _____

Caesarean Sections _____

Type of Birth Control _____

Date of Last . . .

Gynecological Exam _____

Pap Smear _____

Mammogram _____

Menstrual Period _____

Are you currently or possibly pregnant?

Yes No

MALES ONLY

Do you have:

Changes in Urine Stream

Lumps in Testicles

Prostate Trouble

Sex Concerns

Date of Last Prostate Exam _____

PAST MEDICAL HISTORY

(Check only the ones you **HAVE HAD** in the past.):

Hay Fever	<input type="checkbox"/>
Mumps	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>
Allergies	<input type="checkbox"/>
Angina	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Tumor	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>
Skin Trouble	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>
Liver Trouble	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>
Parasites	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>
Polio	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>
Nervous Breakdown	<input type="checkbox"/>
Migraine	<input type="checkbox"/>
Gout	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Bladder Trouble	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>
Kidney Infections	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Dysentery	<input type="checkbox"/>

TESTS: Please list the MOST recent date.

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

Other: _____

HABITS:

	YES	NO	IF YES, PLEASE DESCRIBE:
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: <input type="checkbox"/> 0 - 1/2 <input type="checkbox"/> 1/2 - 1 <input type="checkbox"/> 2 or more Duration: _____
Alcohol Consumption	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks per day: _____ # Drinks per week: _____
Coffee or Tea Consumption	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day: _____
Other Drug Use (Street Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Type: _____

Patient Name _____ Date _____

Are you: Right handed Left handed Ambidextrous

MEDICINES: Please list all currently used medicines and reason for taking them. Include prescription and nonprescription drugs, vitamins, herbs, etc.

ALLERGIES: Please list all known allergies, especially to medicines. _____

Treatment you are receiving or have received:

Medical Care Chiropractic Care Other: _____

Do you currently have or have you had in the past:

(Please mark all that apply.)

	Currently	Past	
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	→ When, # episodes _____
Elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	→ When, # episodes _____
Wrist/hand pain	<input type="checkbox"/>	<input type="checkbox"/>	→ When, # episodes _____
Hip pain	<input type="checkbox"/>	<input type="checkbox"/>	→ When, # episodes _____
Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	→ When, # episodes _____
Foot pain or trouble	<input type="checkbox"/>	<input type="checkbox"/>	→ When, # episodes _____

In general, how would you rate your health? Excellent Average Poor

Do you feel depressed or have trouble falling asleep, poor appetite, lack of interest in normally enjoyable activities, relationship problems? No Yes

If yes, please explain: _____

Patient Name _____ Date _____

ABOUT YOUR FAMILY HISTORY:

Please mark relative's current age or age at time of death, place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy-Asthma	Alcohol Abuse	Arthritis-Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spin or Back Disorder	Stroke	Tuberculosis	Chronic Pain	Other	If deceased, cause of death
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brothers & Sisters #1																				
#2																				
#3																				
#4																				
#5																				
Spouse																				
Children #1																				
#2																				
#3																				
#4																				
#5																				

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENTS, or WORK INJURIES

Areas Involved (indicate Evaluations & Treatment). Please be as specific as possible.

Year

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

SERIOUS ILLNESSES (List current and past illnesses not mentioned above (including cancer, diabetes, etc.))

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____