

**Patient Information**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 (First, Middle, Last )

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name by Which You Wish to be Addressed: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed E-mail Address: \_\_\_\_\_

Primary Language:  English  Other: \_\_\_\_\_

**Race:**  American Indian or Alaska Native  Asian  Black or African American  Hispanic or Latino  Native Hawaiian  
 White  Declined to Specify **Ethnicity**  Non Hispanic or Non Latino  Hispanic or Latino  Withheld

Primary Care Physician's Name: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group #: \_\_\_\_\_

When was your last visit to Capitol Chiropractic Health Center? \_\_\_\_\_

**Employment Information**

Employment Status:  Employed  Unemployed  Full-Time Student  Part-Time Student  Other \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Person Responsible for Payment (if other than Patient)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Past Health History**

**Hospitalizations - please list any and all hospitalizations since your last visit to our office.**

Year	Hospital	Reason for Hospitalization and Outcome

**Surgeries - please list any and all surgeries since your last visit to our office.**

Year	Type	Reason for Surgery and Outcome

**Injuries - please list any and all injuries since your last visit to our office.**

Year	Description of Injury and Areas injured

**Present Complaints**

**1. Chief Complaint and Location:** \_\_\_\_\_

How did this occur:  Injury at work  Auto Accident  Accident (Fall, etc. )  
 Other, Please describe: \_\_\_\_\_

Date of injury and/or onset of symptoms: \_\_\_\_\_

Does your pain radiate (travel) or is it localized? If it radiates, please describe where it travels from and to. \_\_\_\_\_

Does your pain occur at work, home, during exercise, AM, PM, etc.? \_\_\_\_\_

Please rate the intensity of your pain. 0=No Pain, 10=Excruciating Pain. Circle 0 1 2 3 4 5 6 7 8 9 10

Is your pain constant, intermittent, or constant w/ ranging degrees of intensity? If intermittent indicate what % (0-100) of time it occurs. \_\_\_\_\_

Have your symptoms gotten better, stayed the same, or gotten worse? \_\_\_\_\_.

What treatments have you tried yourself for this condition? Have they helped or made your pain worse? \_\_\_\_\_

**2. Second Complaint and Location:** \_\_\_\_\_

How did this occur:  Injury at work  Auto Accident  Accident (Fall, etc.)

Other, Please describe: \_\_\_\_\_

Date of injury and/or onset of symptoms: \_\_\_\_\_

Does your pain radiate (travel) or is it localized? If it radiates, please describe where it travels from and to. \_\_\_\_\_

Does your pain occur at work, home, during exercise, AM, PM, etc.? \_\_\_\_\_

Please rate the intensity of your pain. 0=No Pain, 10=Excruciating Pain. Circle 0 1 2 3 4 5 6 7 8 9 10

Is your pain constant, intermittent, or constant w/ ranging degrees of intensity? If intermittent indicate what % (0-100) of time it occurs. \_\_\_\_\_

Have your symptoms gotten better, stayed the same, or gotten worse? \_\_\_\_\_

What treatments have you tried yourself for this condition? Have they helped or made your pain worse? \_\_\_\_\_

**Previous Treatment of above Complaint(s)**

1. Physician Name: \_\_\_\_\_ Type of Physician: \_\_\_\_\_

Date(s) of Visit (s): \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Result of Treatment: \_\_\_\_\_

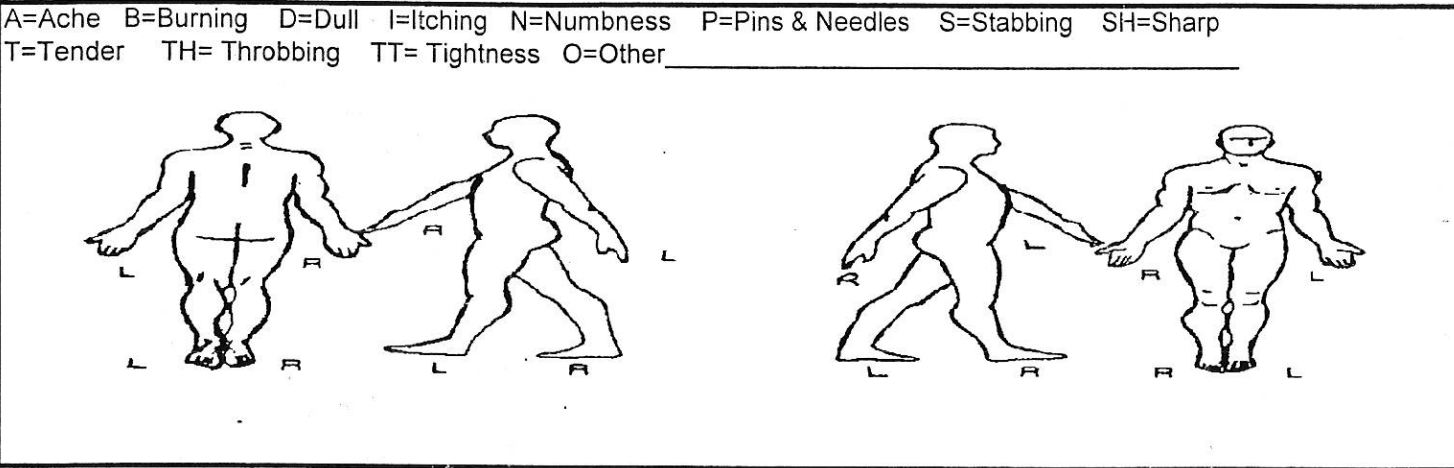
2. Physician Name: \_\_\_\_\_ Type of Physician: \_\_\_\_\_

Date(s) of Visit (s): \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Result of Treatment: \_\_\_\_\_

**Pain Diagram and Descriptors. Use the letters below to indicate the type and location of pain, discomfort and sensations.**

A=Ache B=Burning D=Dull I=Itching N=Numbness P=Pins & Needles S=Stabbing SH=Sharp  
T=Tender TH=Throbbing TT=Tightness O=Other \_\_\_\_\_



In reference to the following descriptors, check the appropriate box as to what activities increase or decrease your symptoms

	Increase	Decrease		Increase	Decrease
With a Cough/Sneeze	<input type="checkbox"/>	<input type="checkbox"/>	Lying flat on back	<input type="checkbox"/>	<input type="checkbox"/>
Sitting Down	<input type="checkbox"/>	<input type="checkbox"/>	Lying on Stomach	<input type="checkbox"/>	<input type="checkbox"/>
Driving an Automobile	<input type="checkbox"/>	<input type="checkbox"/>	Lying on side w/ knees bent	<input type="checkbox"/>	<input type="checkbox"/>
Bending over to Brush Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Strain w/ Bowel Movement	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	Middle of the Night	<input type="checkbox"/>	<input type="checkbox"/>
At the End of the Day	<input type="checkbox"/>	<input type="checkbox"/>	Upon Wakening	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other activities, etc. which increase or decrease your symptoms not listed above. \_\_\_\_\_

Smoking Status  Current every Day Smoker  Current Periodic Smoker: How Often \_\_\_\_\_  
 Former Smoker: Year Started \_\_\_\_ Year Quit \_\_\_\_\_  Never Smoker

**type and Quality of Tobacco**

- Chews Number of pouches per week? \_\_\_\_\_
- Cigarettes Number of Packs/day? \_\_\_\_\_
- Cigars Number per week? \_\_\_\_\_
- Dips Cans per week? \_\_\_\_\_
- Pipe Number of Pipfuls per day? \_\_\_\_\_

**Medications - List any and all medications you are presently taking**

Name of Medication	Dosage	Reason for Taking

**Vitamins/Supplements - List any and all vitamins/supplements you are presently taking**

Name of Vitamin/Supplement	Dosage	Reason for Taking

**Allergies: ( Medications, Food, Other)**


Patient Signature:

Date:

**For Office Use Only**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_/\_\_\_\_ Sitting Y N Left arm Right arm

BMI Calculated

Growth Charts for Children ( 0-20 years of age)