

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 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: _____

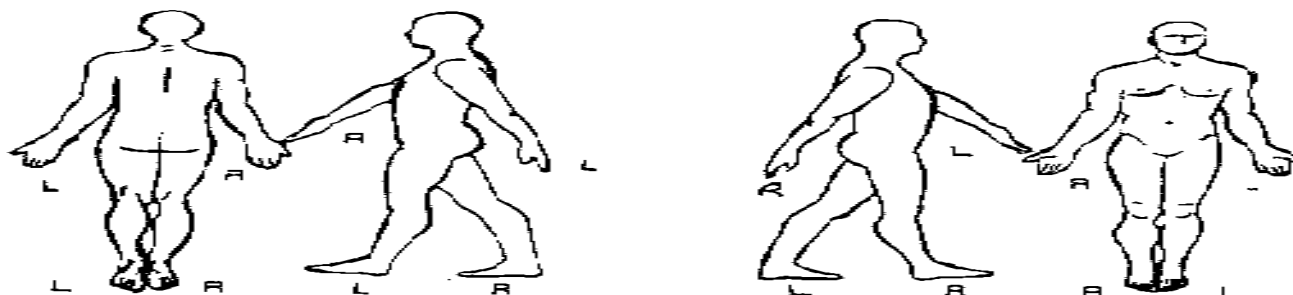
2. Physician Name: _____ Type of Physician: _____

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. _____

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: _____