

**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: \_\_\_\_\_

How were you referred to the office?  By a Physician  Yellow Pages  Lecture  Exhibit  By a Patient

Please print the name of reference source \_\_\_\_\_

Are you a FitClub Member?  Yes  No

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

**Employment Information**

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

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

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

**Spouse Information**

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

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

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

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

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

**Emergency Contact Person**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Past Health History**

**Hospitalizations - please list any and all hospitalizations**

Year	Hospital	Reason for Hospitalization and Outcome

**Surgeries - please list any and all surgeries**

Year	Type	Reason for Surgery and Outcome

**Injuries - please list any and all injuries**  
 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 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? \_\_\_\_\_

**3. Third 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: \_\_\_\_\_

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

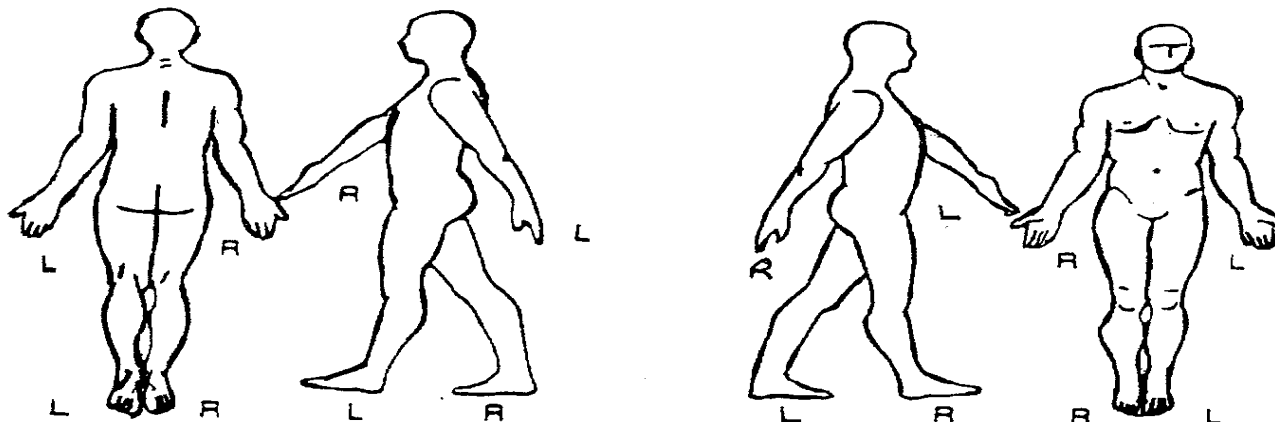
Date(s) of Visit (s): \_\_\_\_\_ Diagnosis: \_\_\_\_\_

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

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\_\_\_\_\_

Use the above letters to indicate type and location of pain, discomfort and sensations.



In reference to the following descriptions, 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"/>	Upon awakening	<input type="checkbox"/>	<input type="checkbox"/>
At the End of the Day	<input type="checkbox"/>	<input type="checkbox"/>	Middle of the Night	<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)**


## REVIEW OF SYSTEMS

The items below may relate to your current condition. In the space in front of each item, place a "C" if you CURRENTLY have the problem and an "P" if you HAD the problem in the past. Leave space blank if you NEVER had the problem.

### GENERAL

1. \_\_\_\_\_ Fever
2. \_\_\_\_\_ Chills
3. \_\_\_\_\_ Night Sweats
4. \_\_\_\_\_ Loss of Sleep/Insomnia
5. \_\_\_\_\_ Fatigue
6. \_\_\_\_\_ Nervousness
7. \_\_\_\_\_ Weight Loss or Gain
8. \_\_\_\_\_ Allergies
9. \_\_\_\_\_ Bleeding Problems
10. \_\_\_\_\_ Anemia
11. \_\_\_\_\_ Diabetes
12. \_\_\_\_\_ Cancer
13. \_\_\_\_\_ Depression
14. \_\_\_\_\_ Alcoholism
15. \_\_\_\_\_ Anorexia
16. \_\_\_\_\_ Bulimia
17. \_\_\_\_\_ Bronchitis
18. \_\_\_\_\_ Cataracts
19. \_\_\_\_\_ Emphysema
20. \_\_\_\_\_ Water Retention
21. \_\_\_\_\_ Glaucoma
22. \_\_\_\_\_ Goiter
23. \_\_\_\_\_ Gout
24. \_\_\_\_\_ Hepatitis
25. \_\_\_\_\_ High Cholesterol
26. \_\_\_\_\_ Measles
27. \_\_\_\_\_ Migraine Headaches
28. \_\_\_\_\_ Mononucleosis
29. \_\_\_\_\_ Multiple Sclerosis
30. \_\_\_\_\_ Mumps
31. \_\_\_\_\_ Polio
32. \_\_\_\_\_ Rheumatic Fever
33. \_\_\_\_\_ Scarlet Fever
34. \_\_\_\_\_ Thyroid Problems
35. \_\_\_\_\_ Typhoid fever
36. \_\_\_\_\_ Chronic Fatigue Syndrome
37. \_\_\_\_\_ Cold Sores
38. \_\_\_\_\_ Diphtheria
39. \_\_\_\_\_ Lupus
40. \_\_\_\_\_ Malaria
41. \_\_\_\_\_ Pleurisy
42. \_\_\_\_\_ Whooping Cough
43. \_\_\_\_\_ Chicken Pox

### WOMEN ONLY

44. \_\_\_\_\_ Live Births # \_\_\_\_\_
45. \_\_\_\_\_ Miscarriage # \_\_\_\_\_
46. \_\_\_\_\_ Hot Flashes
47. \_\_\_\_\_ Painful Periods
48. \_\_\_\_\_ Excessive Flow
49. \_\_\_\_\_ Irregular Cycles
50. \_\_\_\_\_ Vaginal Burning/Itching
51. Date Last Period: \_\_\_\_\_
52. Date Last Mammogram: \_\_\_\_\_
53. Birth Control Type: \_\_\_\_\_
54. Date of Last Pap: \_\_\_\_\_

### MEN ONLY

55. \_\_\_\_\_ Testicular Pain/Swelling
56. \_\_\_\_\_ Prostate Problems

### RESPIRATORY

57. \_\_\_\_\_ Difficulty Breathing
58. \_\_\_\_\_ Chronic Cough
59. \_\_\_\_\_ Spitting Phlegm
60. \_\_\_\_\_ Spitting Blood
61. \_\_\_\_\_ Wheezing/Asthma
62. \_\_\_\_\_ Pneumonia
63. \_\_\_\_\_ Tuberculosis

### CARDIOVASCULAR

64. \_\_\_\_\_ Irreg. Heartbeat Rapid or Slow
65. \_\_\_\_\_ High/ Low Blood Pressure
66. \_\_\_\_\_ Pain Over Heart
67. \_\_\_\_\_ Previous Heart Trouble
68. \_\_\_\_\_ Ankle Swelling
69. \_\_\_\_\_ Varicose Veins
70. \_\_\_\_\_ Rheumatic Fever
71. \_\_\_\_\_ Stroke
72. \_\_\_\_\_ Heart Attack
73. \_\_\_\_\_ Poor Circulation
74. \_\_\_\_\_ Pacemaker/Defibrillator
75. \_\_\_\_\_ Arteriosclerosis

### GENITO-URINARY

76. \_\_\_\_\_ Frequent Urination
77. \_\_\_\_\_ Painful Urination
78. \_\_\_\_\_ Blood in Urine
79. \_\_\_\_\_ Kidney Infection
80. \_\_\_\_\_ Kidney Disease
81. \_\_\_\_\_ Urinary Infection
82. \_\_\_\_\_ Inability to Control Urination
83. \_\_\_\_\_ Difficulty Starting Urine Flow
84. \_\_\_\_\_ Get up \_\_\_\_\_ times/ night to urinate
85. \_\_\_\_\_ Breast Lump or Pain
86. \_\_\_\_\_ Sexual Difficulties
87. \_\_\_\_\_ Bedwetting
88. \_\_\_\_\_ Venereal Infection/Disease  
Type \_\_\_\_\_
89. \_\_\_\_\_ Vaginal Infections

### SKIN

90. \_\_\_\_\_ Itching
91. \_\_\_\_\_ Bruising Easily
92. \_\_\_\_\_ Change in Mole(s)
93. \_\_\_\_\_ Skin Cancer
94. \_\_\_\_\_ Dry Skin
95. \_\_\_\_\_ Eczema
96. \_\_\_\_\_ Psoriasis
97. \_\_\_\_\_ Scars/Location \_\_\_\_\_
98. \_\_\_\_\_ Rash or Hives

### NEUROLOGIC

99. \_\_\_\_\_ Weakness
100. \_\_\_\_\_ Twitching
101. \_\_\_\_\_ Tremors
102. \_\_\_\_\_ Headache
103. \_\_\_\_\_ Fainting
104. \_\_\_\_\_ Dizziness
105. \_\_\_\_\_ Convulsions
106. \_\_\_\_\_ Epilepsy
107. \_\_\_\_\_ Numbness/Tingling
108. \_\_\_\_\_ Arm/Leg Pain
109. \_\_\_\_\_ Mental Disorder

### MUSCULOSKELETAL

110. \_\_\_\_\_ Neck Stiffness/Pain
111. \_\_\_\_\_ Pain Between Shoulders
112. \_\_\_\_\_ Low Back Pain
113. \_\_\_\_\_ Swollen Joints/Bursitis
114. \_\_\_\_\_ Painful Joints
115. \_\_\_\_\_ Muscle Aches/Soreness
116. \_\_\_\_\_ Spinal Curvature
117. \_\_\_\_\_ Osteoarthritis
118. \_\_\_\_\_ Rheumatoid Arthritis

### EYE, EAR, NOSE, THROAT

119. \_\_\_\_\_ Hoarseness
120. \_\_\_\_\_ Poor Vision/Failing
121. \_\_\_\_\_ Pain in Eye(s)
122. \_\_\_\_\_ Gum Problems
123. \_\_\_\_\_ Nosebleeds
124. \_\_\_\_\_ Nose Problems
125. \_\_\_\_\_ Sinus Trouble
126. \_\_\_\_\_ Dental Problems
127. \_\_\_\_\_ Tonsillitis
128. \_\_\_\_\_ Tonsillectomy
129. \_\_\_\_\_ Deafness/Difficulty Hearing
130. \_\_\_\_\_ Ringing in Ears
131. \_\_\_\_\_ Sore Throat
132. \_\_\_\_\_ Swollen/Enlarg. Glands

### GASTROINTESTINAL

133. \_\_\_\_\_ Leaky Gut Syndrome
134. \_\_\_\_\_ Heartburn
135. \_\_\_\_\_ Poor Appetite
136. \_\_\_\_\_ Poor Digest./Indigestion
137. \_\_\_\_\_ Difficulty Swallowing
138. \_\_\_\_\_ Belching or Gas
139. \_\_\_\_\_ Frequent Nausea
140. \_\_\_\_\_ Vomiting w/wo Blood
141. \_\_\_\_\_ Pain Over Abdomen
142. \_\_\_\_\_ Ulcer
143. \_\_\_\_\_ Black or Bloody Stools
144. \_\_\_\_\_ Liver Problems
145. \_\_\_\_\_ Gall Bladder Problems
146. \_\_\_\_\_ Jaundice
147. \_\_\_\_\_ Hernia
148. \_\_\_\_\_ Diarrhea
149. \_\_\_\_\_ Constipation
150. \_\_\_\_\_ Hemorrhoids
151. \_\_\_\_\_ Appendicitis
152. \_\_\_\_\_ Excessive Thirst
153. \_\_\_\_\_ Acid Reflux

### HABITS

154. \_\_\_\_\_ Alcohol \_\_\_\_\_ #drinks/Day
155. \_\_\_\_\_ Recreational Drug Use
156. \_\_\_\_\_ Tobacco/Smoking \_\_\_\_\_ #pks/Day
157. \_\_\_\_\_ Sugar/Substitutes \_\_\_\_\_ amt./Day
158. \_\_\_\_\_ Caffeinated Drinks  
# \_\_\_\_\_ Cups/Day  
# \_\_\_\_\_ Cans/Day

## FAMILY HEALTH HISTORY

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER (S)		SISTER (S)		CHILDREN	
	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____
Allergies									
Arthritis									
Asthma-hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc problem									
Emotional Problems									
Emphysema									
Epilepsy									
Gastrointestinal disorders									
Headaches									
Heart Disease									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Disease									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Syphilis									
Other									
Other									
Other									

If any of the above family members are deceased, please list their age at death and cause: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Consent to Treatment**

I voluntarily consent to receive chiropractic and health care services that may include diagnostic procedures, examinations and treatment.

Our doctors will discuss your health history, perform an examination and discuss recommendations with you. They only accept cases based on examination findings and diagnostic tests. There are no guarantees or promises of improvement or complete recovery. We will ask you many questions pertaining to your health, pain, and present condition. Please give the doctor as much information as you can remember.

Your signature below fully authorizes our staff and doctors to perform any examination, diagnostic test and or treatment we may consider medically necessary, and to release all information pertinent to your health, insurance, or benefits to any and all applicable parties on your behalf.

**Financial Responsibility and Assignment of Benefits**

I agree to pay all services and or fees accrued on my account, including but not limited to chiropractic services, supplements, supplies, missed appointment fees, service charges and/or collection fees.

**I certify that I have read this form and understand its content.**

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

\_\_\_\_\_  
 ( Patient Signature or Other Legally Authorized Person)

Information Checked/Witnessed By: \_\_\_\_\_ Date: \_\_\_\_\_