Capitol Chiropractic Health Center
3631 South 6th Street, Suite B
Springfield, IL 62703
(217) 391-5446

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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. _____

_____

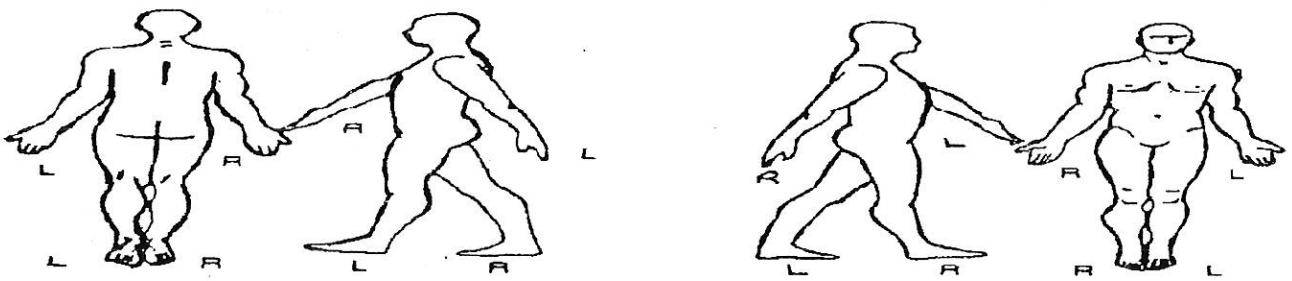
Does your pain occur at work, home, during exercise, AM, PM, etc.? _____
Please rate the intensity of your pain. 0=No Pain, 10=Excruciating Pain. Circle 0 1 2 3 4 5 6 7 8 9 10
Is your pain constant, intermittent, or constant w/ ranging degrees of intensity? If intermittent indicate what % (0-100) of 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 activites increase or decrease your symptoms

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

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)**