PATIENT INFORMATION

Date_____/_____/_____

Name_____SS#_____-_____-_____
First MI Last

Preferred Name/Nickname_____

Address_____City_____State____Zip_____

Phone# (_____) _____ E-mail _____

Sex: [ ] F [ ] M Age _____ Birth date_____

Occupation_____Employer_____

Emergency contact_____ Relation to patient _____

Phone (____) _____

Whom may we thank for referring you to us? _____

PATIENT CONDITION

Reason for visit: [ ] Wellness Care [ ] Symptomatic Care

When was the last time you received chiropractic care? _____

Symptoms (describe) _____

When did the symptoms appear? _____

Is it progressively worse? [ ] yes [ ] no [ ] same [ ] better

Rate the severity (1=mild, 10=severe) 1 2 3 4 5 6 7 8 9 10

Is it constant? [ ] yes [ ] no

How often do you have this pain? _____

Type of pain: [ ]sharp [ ]dull [ ]throbbing [ ]numbness [ ]aching [ ]shooting
[ ] burning [ ] tingling [ ] cramps [ ] stiffness [ ] swelling [ ] other_____

Which activities are difficult to perform? [ ] working [ ] sitting [ ] standing
[ ] walking [ ] laying down [ ] bending [ ] sleeping [ ] other_____

What treatment have you received for your condition? _____

Doctors who have treated you for your condition _____

Who is your primary care physician? _____

Are you under medication for this condition? [ ] no [ ] yes. If yes please list them on the *health history* information page

QUESTIONNAIRE

What do you think is going on? _____

How is this condition affecting your life? _____

How long do you expect that it will take for your pain to decrease? _____

If your symptoms went away, would you consider yourself healthy? _____

Have you or your family ever been to a wellness chiropractor before? _____