Patient Data

Title: _____

First Name: _____ MI: Last Name: _____

Nickname: _____

Address: _____

_____

City: _____ State: Zip Code: _____

Home Phone:( ) _____ Work Phone:( ) _____ Cell:( ) _____

Birth Date: _____ Sex: _____

E-Mail _____

SSN: - - Marital Status:(circle one): Single Married Other

Emp. Status: Emp F/T Student P/T Student Other

Spouse's Name: _____

Spouse Ph.#( ) _____ WorkPh.#( ) _____ Cell#( ) _____

Spouse DOB: _____ Spouse SS# _____

PATIENT
Employer Name: _____

Employer Address: _____ Phone#( ) _____

Emergency Contact: _____ Phone#( ) _____

Family Physician: _____ Phone#( ) _____

Ins. Company: _____ Ins.Phone#( ) _____
ID#: _____ Group#: _____
Name of Policy Holder: _____ Policy Holder DOB: _____
Policy Holders Employer: _____

Have you ever been under Chiropractic Care? Yes No If so, Who? _____

Referred by: _____

Describe your symptoms: _____ _____

When did your symptoms start? _____

How did your symptoms begin? _____ _____

1. **How often do you experience your symptoms?**

___Constantly (76-100% of the day) ___Frequently (51-75% of the day)
___Occasionally (26-50%of the day) ___Intermittently (0-25%of the day)

2. **What describes the nature of your symptoms?**

___Sharp ___Dull ache ___Numb ___Shooting ___Burning ___Tingling

3. **How are your symptoms changing?**

___Getting Better ___ Not Changing ___Getting Worse

4. **During the past 4 weeks, indicate the average intensity of your symptoms:**

___0-None ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10-Unbearable

5. **During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework)?**

___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

6. **During the past 4 weeks, how much of the time has your condition interfered with your social activities?**

___All of the time ___Most of the time ___Some of the time ___None of the time

7. **In general would you say your overall health right now is...?**

___Excellent ___Very Good ___Good ___Fair ___Poor

8. **Who have you seen for your symptoms?**

___No one ___Other Chiropractor ___Medical Doctor ___Physical Therapist ___Other

9. **What treatment did you receive for your symptoms?**

___Adjustments ___Physical Therapy ___Medication ___Surgery ___Other

10. **When did you receive this treatment?**

___In the last month ___2-6 months ago ___6 months to 1 year ago ___1 yr. or longer

11. **What tests have you had for your symptoms?**

___Xrays ___MRI ___CT Scan ___Other

12. **When were these tests done?**

___In the last month ___2-6 months ago ___6 months to 1 year ago ___1 yr. or longer

13. **Have you had similar symptoms in the past?**

____Yes ____No

14. **If you have received treatment in the past for the same or similar symptoms, who did you see?**

___This Office ___Other Chiropractor ___Medical Doctor ___Physical Therapist ___Other

15. **What is your occupation?**

___Professional/Executive ___WhiteCollar/Secretarial ___Tradesperson ___Laborer
___Homemaker ___FT Student ___Retired ___Other

16. **If you are not retired, a homemaker, or a student, what is your current work status?**

___Full-time ___Part-time ___Self-employed ___Unemployed ___Off work ___Other