

Confidential Patient Information

Date _____

First Name: _____ Initial: _____ Last Name: _____ Name you prefer: _____

Major Complaint Information

What is your major complaint(s)? _____

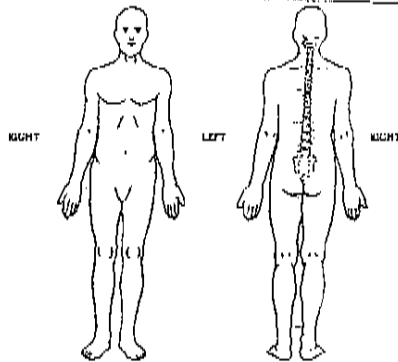
When did this symptom(s) begin? _____

Describe what happened _____

Did these symptoms develop from? Auto Accident Work-Related Injury

Have you reported this to your: insurance company? Yes No employer? Yes No

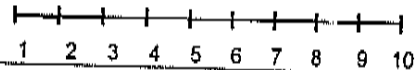
Mark your areas of pain using the Pain Index on the right.



Pain Index

P	Pain
B	Burning
St	Stabbing
S	Sharp
C	Constant

On a scale of 1-10 (1 being best, 10 being worst), please circle how bad the pain is when you feel the worst.



Have you experienced these symptoms before? Yes No When? _____

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Have you seen a doctor for this condition? Yes No Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes No

If so, how many times do you wake up in pain per night? _____

In what position do you sleep? Back Side Stomach

Have you tried a heating pad? Yes No How does it affect the pain? _____

Have you tried a cold pack? Yes No How does it affect the pain? _____

Do you wear a heel lift? Yes No if so, which side? Right Left

Does it cause pain to cough, grunt or sneeze? Yes No If so, where? _____

Name of family physician: _____ Phone # _____

If female, are you pregnant? Yes No Not sure If yes, what is your due date: _____

Please check the activities that aggravate your complaint.

- Lying on Back
- Lying on side with knees bent
- Turning over in bed
- Lying flat on stomach
- Getting in/out of car
- Gripping
- Climbing
- Dressing self
- Kneeling
- Sleeping
- Pushing
- Pulling
- Reaching
- Walking
- Stooping
- Sitting
- Bending forward
- Bending backward
- Standing for periods over one hour
- Sneezing
- Coughing

List all medications you are taking now, including over the counter medication. _____

Are you allergic to any medications: Yes No Not sure Please list: _____

Have you ever had any surgeries or hospitalizations? Yes No Please List: _____

Type of Hospitalization/Surgery: _____ Date: _____ Type of Hospitalization/Surgery: _____ Date: _____

Have you ever been seen by a chiropractor before? Yes No Please List: _____

Name of chiropractor: _____ Date: _____ Name of chiropractor: _____ Date: _____

Fill out the next three sections as they apply to you.

Headaches

Do you have a family history of headaches? Yes No Do you get headaches? Yes No Frequency _____

Do you experience the following along with your headaches: Pain or cracking in your jaw? Yes No

Abnormal blood pressure? Yes No High Low Nausea, Vomiting or Visual disturbances? Yes No

When was your last eye exam by a doctor? 1-6 months 6-12 months 1-2 years over 2 years Results: _____

Lower Back

Do you ever experience ripping or tearing sensations in your back? Yes No If so, where? _____

Does pain radiate to the abdomen? Yes No

Do you ever have impairment of bowel or urinary function? Yes No Explain: _____

Neck

If you have a neck injury, does it affect: (Check all that apply) hearing vision balance cause ringing in your ears

Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No

Do you feel ripping or tearing? Yes No Where? _____

Do you have difficulty lifting or turning your head? Yes No If so, in which direction? Right Left Up Down

Please check all additional complaints that you have at this time.

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Loss of Concentration | <input type="checkbox"/> Neck Motion Restricted | <input type="checkbox"/> Irritable | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> HIV (Aids) |
| <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Upper Back Pain/Stiffness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other (Please List) |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Mid Back Pain/Stiffness | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Heavy Feeling of Head | <input type="checkbox"/> Lower Back Pain/Stiffness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Right/Left Shoulder Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Right/Left Arm Pain | <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Convulsions | _____ |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Right/Left Leg Pain | <input type="checkbox"/> Excess Perspiration | <input type="checkbox"/> Allergies (Please List) | _____ |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Pins & Needles Arms/ Legs | <input type="checkbox"/> Digestive Trouble | <input type="checkbox"/> Numbness _____ | _____ |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swelling _____ | _____ |
| <input type="checkbox"/> Pain Behind Eyes | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cuts _____ | _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bleeding _____ | _____ |
| <input type="checkbox"/> Palpitation | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Broken Bones _____ | _____ |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Bruising _____ | _____ |
| | | <input type="checkbox"/> Anemia | | |
| | | <input type="checkbox"/> Heart Disease | | |

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If so, please list: _____

Any additional information you would like the doctor to know about before beginning care at Chiropractic Village? _____

Emergency Contact

Name: _____ Relation: _____
 Address: _____
 Home Phone: _____ Work Phone: _____

Please provide your insurance card to be photocopied or fill out the information below.

Insurance Company: _____ Phone # _____
 Insured's Name: _____ Insured's SS# _____ Group # _____
 Insured's Birth Date: _____ Insured's Employer: _____

Personal Information

Address: _____
 Home Phone: _____ Work Phone: _____
 Social Security #: _____ Birth Date: _____ Age: _____ Sex M F
 Marital Status: S M D W Spouse's Name: _____ # of Children _____
 Occupation: _____ Employer's Name: _____
 Work Address: _____
 How did you hear about Chiropractic Village? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Chiropractic Village to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Chiropractic Village responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date