Patient Information Form

Patient Name: ______________________________________ Date: _________________________

Date of Birth: ______________ Sex: ______ SSN: ________________ Single: _______ Married: ______

Address:____Apt:_____________

City:_______________________________State:____________________Zip:______________________

Cell Number: (____) ___________________Work: (____) _____________Home (____) _____________

Email Address: ____________________________________ Height: _____________ Weight: ________

Occupation: _______________________________ Employer: _________________________________

Primary Policy Holder: ____________________________Policy Holder's Date of Birth: ______________

Secondary Policy Holder:_________________________ Policy Holder's Date of Birth: ______________

Tertiary Policy Holder:____________________________ Policy Holder's Date of Birth: ______________

Have you seen a Chiropractor before? **Yes** **No** If Yes, when? _______________________________

Whom may we thank for referring you to our office? ____

Briefly describe the reason that you are seeking care: ____

____

Are you pursuing a personal injury, accident, disability, or worker's compensation case? **Yes** **No**

If yes, what type of case? ________________________ Attorney Name: _________________________

Medications: ____

____

Primary Care Physician: ____

This office conforms to the current HIPAA guidelines.
You may request a copy of our HIPAA policy at the front desk.
Please initial to indicate you have been made aware of our HIPAA policy: _________________.

I understand that any charges incurred at this office are my financial responsibility.
I give this office permission for evaluation and treatment as the chiropractor determines is necessary.

Patient/Guardian Signature: ____ Date: ______________

Chiropractor Signature: ____ Date: ______________

Review of Systems

Patient Name: ______________________________ Date: ____________________

Please mark any symptoms that you have experienced in the past year.

Constitutional/General
- ❑ Fever
- ❑ Chills
- ❑ Heavy sweating or Night sweats
- ❑ Loss of Appetite
- ❑ Sleep Disturbances
- ❑ Unexpected weight loss or gain
- ❑ Night pain
- ❑ Other: ___________

Eyes
- ❑ Blurry vision
- ❑ Double vision
- ❑ Wear glasses
- ❑ Other: ___________

Ear/Nose/Throat
- ❑ Sore throat
- ❑ Mouth sores
- ❑ Nasal congestion/sinus issues
- ❑ Hearing loss
- ❑ Other: ___________

Respiratory
- ❑ Cough
- ❑ COPD
- ❑ Wheezing
- ❑ Recurrent Upper Respiratory Infections
- ❑ Shortness of Breath
- ❑ Difficulty breathing
- ❑ Other:___________

Endocrine
- ❑ Excessive thirst or fluid intake
- ❑ Temperature intolerance
- ❑ Feeling tired (fatigue)
- ❑ Hot flashes
- ❑ Other: ___________

Cardiovascular
- ❑ Chest pain or discomfort
- ❑ Swelling of feet, ankles, or legs
- ❑ Irregular heart beat
- ❑ Heart attack
- ❑ Heart failure
- ❑ Palpitations
- ❑ Varicose veins
- ❑ Other: ___________

Gastrointestinal
- ❑ Abdominal pain
- ❑ Nausea/vomiting
- ❑ Indigestion or heartburn
- ❑ Blood in stool
- ❑ Change in bowel habits
- ❑ Rectal bleeding
- ❑ Diarrhea
- ❑ Constipation
- ❑ Swallowing difficulties
- ❑ Other: ___________

Psychological
- ❑ Depression
- ❑ Anxiety
- ❑ Other: ___________

Hematologic/Lymphatic
- ❑ Swollen glands
- ❑ Blood clotting problem
- ❑ Easy bruising
- ❑ Bleeding tendencies
- ❑ Other: ___________

Genitourinary
- ❑ Frequency urination
- ❑ Loss of urinary control
- ❑ Changes in bladder habits
- ❑ Enlarged prostate
- ❑ Difficulty urinating
- ❑ Painful urination
- ❑ Other: ___________

Skin
- ❑ Skin rash
- ❑ Itching
- ❑ Discoloration of skin
- ❑ Lumps or masses
- ❑ Other: ___________

Musculoskeletal
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Back pain
- ❑ Limitation of motion
- ❑ Neck pain
- ❑ Other: ___________

Neurological
- ❑ Headaches
- ❑ Numbness
- ❑ Tingling
- ❑ Weakness
- ❑ Dizziness/Vertigo
- ❑ Shooting pain
- ❑ Other: ___________

Patient/Guardian Signature: ______________________________ Date: ____________________

Chiropractor Signature: ______________________________ Date: ____________________

ALIGNED

Health History Form

Revised 12/10/2020

Patient Name: ____ Date:_____________________________

Answer the following questions about your health history. Please write legibly.

Do you have any diagnosed health conditions? ________ If Yes, then please explain below.

____

____

Have you had any surgeries or hospitalizations? ________ If Yes, then please explain below.

____

____

Have you had any physical traumas, falls, or injuries? ________ If Yes, then please explain below.

____

____

Do you have any allergies? ____

Are you pregnant or planning to become pregnant? ____

Have you ever had a Heart Attack, Stroke, TIA or Vascular Blockage? ______________________________

Do you have a pacemaker or defibrillator? ____

Have you ever had cancer? ________If yes, please explain: _______________________________________

Do you have any skin Infections or lesions? ______ If yes, please explain: __________________________

Do you have any metal in your body? _______ If yes, please explain: ______________________________

Have you had any recent X-rays or MRI's? _________ List Studies: _________________________________

Do you have Osteoporosis or Osteopenia? ____

Family History: Mother Health Conditions: ____

Father Health Conditions: ____

Patient Signature: ____ Date: _____________________

Chiropractor Signature: ____ Date:______________________

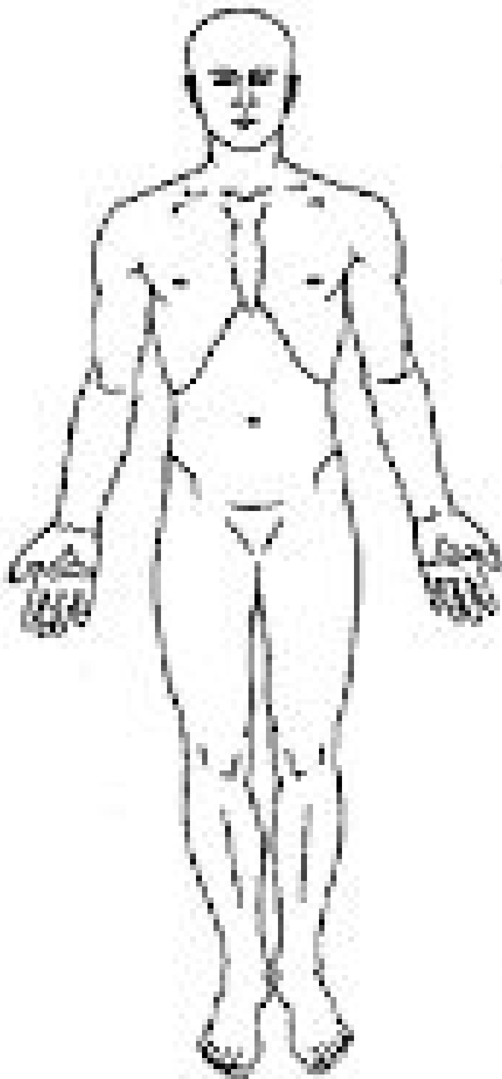
Symptom Diagram

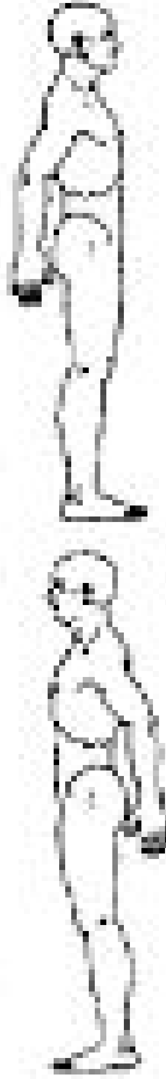
Patient Name : ________________________________ Date: ______________________________

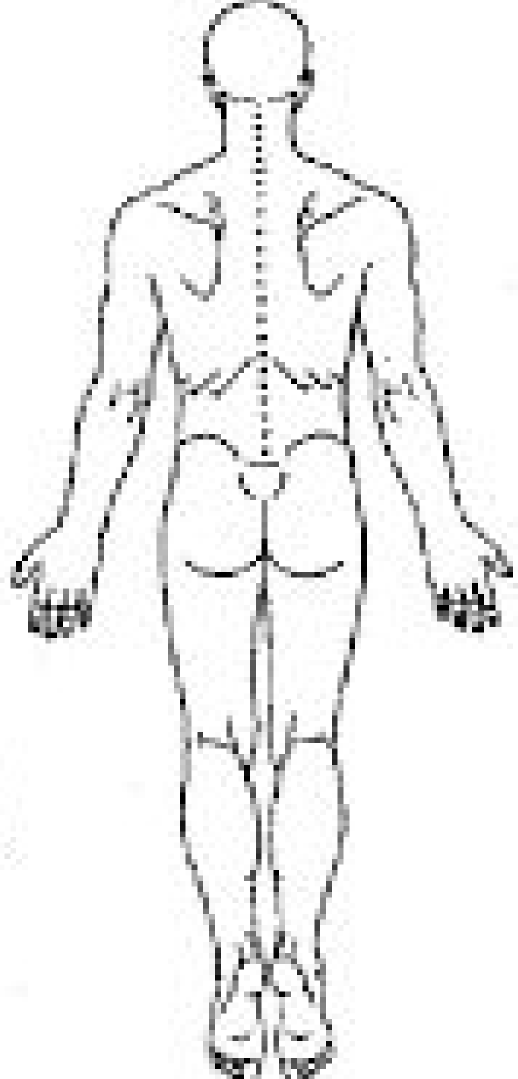
Instructions: Please use the diagram below to indicate the symptoms that you have experienced over the past 24 hours. Use the key to indicate the multiple types of symptoms.

Key:

Pins and needles = 000000	Stabbing = / / / / / /	Numbness = NNNNNN
Burning = XXXXXX	Aching = ZZZZZZ	Pain = PPPPPP
Other = __________	Other = _________	Other = ___________







Patient Signature: _______________________________________ Date: ______________________

Chiropractor Signature: ___________________________________ Date: ______________________

Initial: _____ Re-Eval: _____

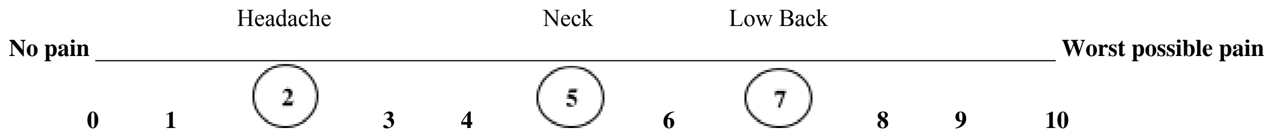
Initial _______ Re-eval _______

QUADRUPLE VISUAL ANALOGUE SCALE

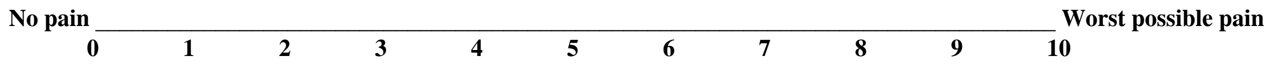
Patient Name ____ Date ____________________________

Instructions: Please circle the number that best describes the question being asked and write the affected area above the number. Please use the example below as a reference.

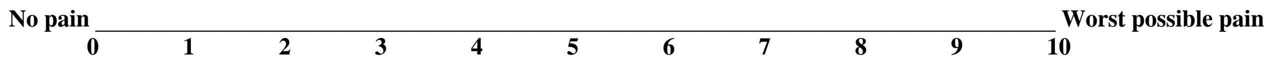
Example:



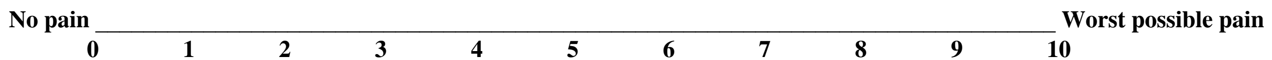
1 – What is your pain RIGHT NOW?



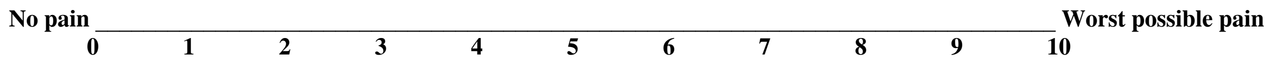
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



Patient Signature ____ **Date** ____________________

Chiropractor Signature ____ **Date** ____________________

SCORE: #1 ______ + #2 ______ + #4 ______ = _______ / 3 x 10 = _________ (Low intensity = <50; High intensity = >50)