Patient Information Form

Demographics

Patient Name: ______________________________________ Date: _________________________

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

Height: _____ Weight: _____ Ethnicity: _______________ Email Address: _________________________

Address:____ Apt:_____________

City:________________________________State:____________________Zip:_______________________

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

Occupation: ________________________________ Employer: ___________________________________

Insurance Information

Primary Policy Holder: _____________________________ Policy Holder's Date of Birth: _____________

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

Health Information

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

How did you find out about 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: ____

Emergency Contact: Name: __________________ Relation: ___________ Phone: (_____)___________

Primary Care Physician: ____ Phone: (_____)___________

This office conforms to the current HIPAA guidelines.
You may request a copy of our HIPAA policy at the front desk.

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.
I understand the risks and benefits of chiropractic care as outlined in the informed consent form.

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: ____________________

Health History Form Revised 10/3/2021

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 ever had any surgeries, medical procedures, or hospitalizations? ________ If Yes, then please explain below.

____

____

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

____

____

Do you have any allergies? _________ If yes please list: ___________________________________

Are you pregnant or planning to become pregnant? ________ If pregnant, how many weeks?_________

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

Do you have a pacemaker, defibrillator, or other implanted device? ______________________________

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? _________ When? ______________ Where? ___________

Do you have Osteoporosis or Osteopenia? ____

Do you use: Alcohol? ____________ Recreational Drugs? ___________Tobacco/Vape?_______________

Family History: Mother Health Conditions:____

Father Health Conditions: ____

Patient / Guardian Signature: __________________________________ Date: ____________________

Chiropractor Signature: _______________________________________ Date:_____________________

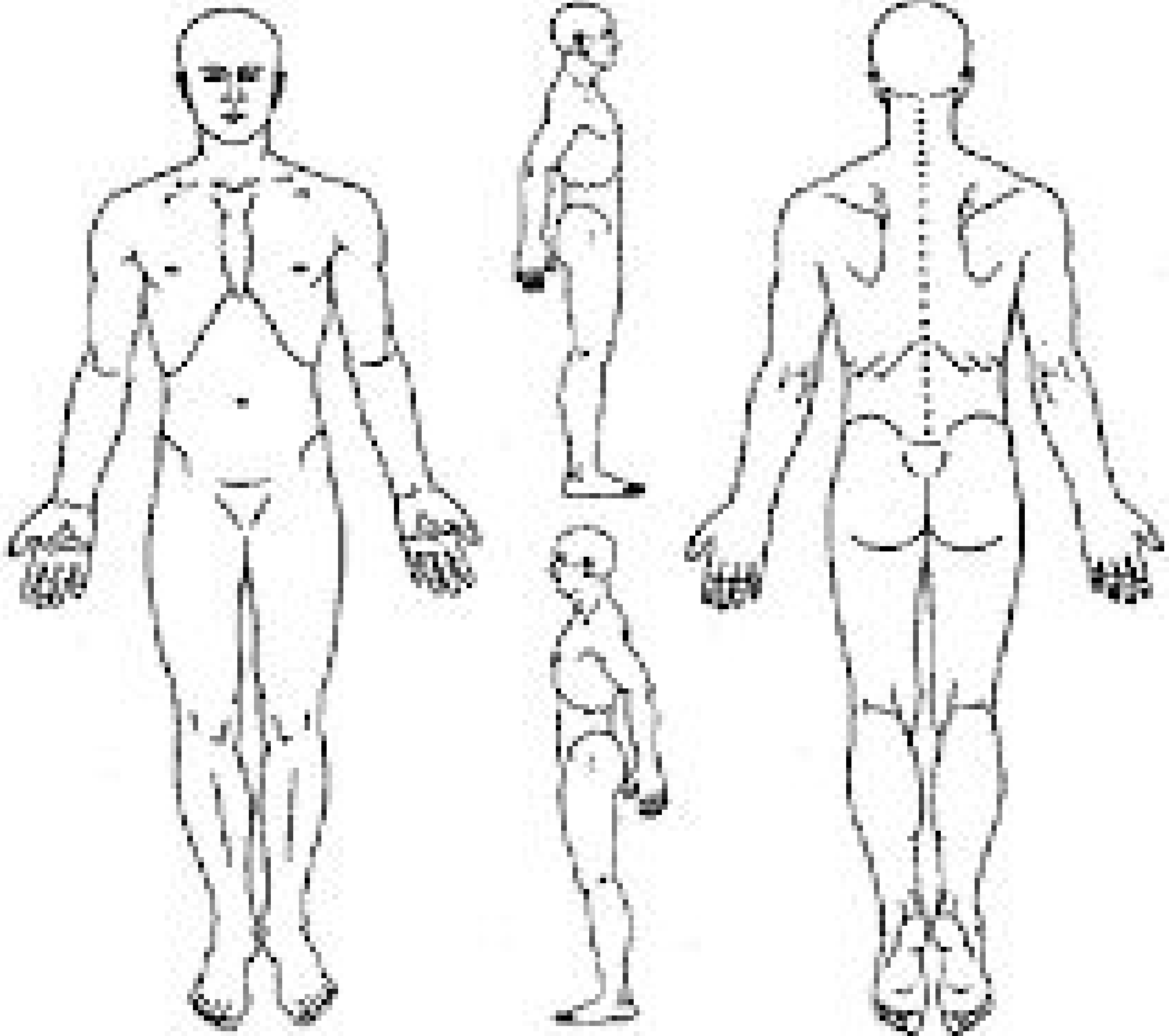
Symptom Diagram

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: _____

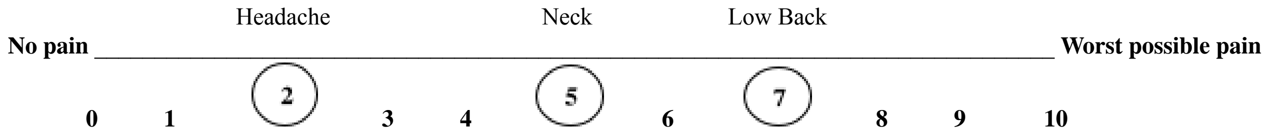
Initial _______ Re-eval _______

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. If you have completed this form before, indicate your pain levels since the last time you completed this form.

Example:



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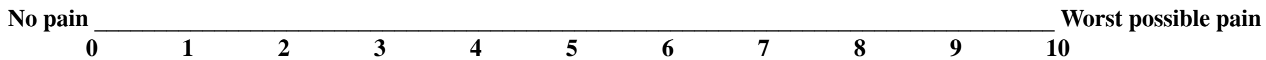
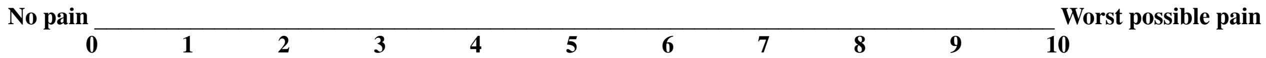
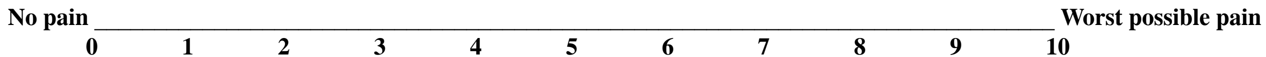
1 – What is your pain RIGHT NOW?



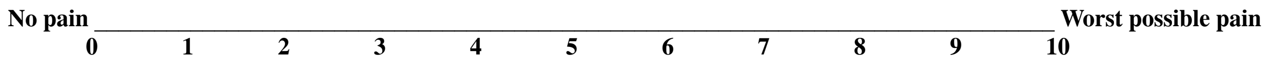
2 – What is your TYPICAL or AVERAGE pain?



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 / Guardian Signature ____ **Date** ____________________

Chiropractor Signature ____ **Date** ____________________

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

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