Clancey Chiropractic

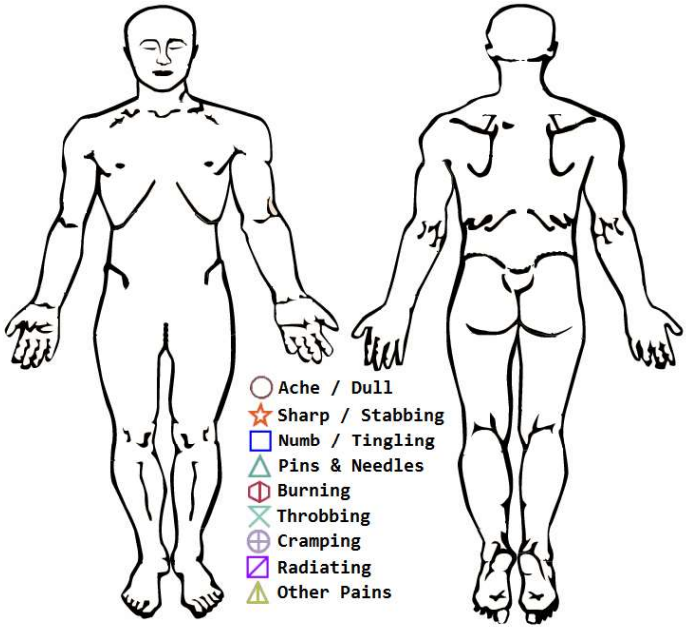
195 South Main St, Ste 1 , Longmont, CO 80501-6218

Phone: 303-651-2060

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	○ Male ○ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Symptoms:



Complaint Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

Date of scheduled appointment _____ When did this condition begin? _____

How long have you had this condition? _____ What caused this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #1 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Complaint #2 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #2 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Complaint #3 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #3 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Complaint #4 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #4 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Mechanism of Injury:

The injury was due to: _____ Date of accident: _____

FOR WORKMAN'S COMPENSATION-RELATED VISITS ONLY:

How did the injury occur? Choose all that apply.

- ☐ Bending
- ☐ Carrying
- ☐ Climbing
- ☐ Crawling
- ☐ Driving (driver)
- ☐ Driving (passenger)
- ☐ Job activity
- ☐ Jumping
- ☐ Kneeling
- ☐ Raising arm(s) above shoulder(s)
- ☐ Repetitive motion
- ☐ Running
- ☐ Sitting
- ☐ Squatting
- ☐ Standing
- ☐ Standing from a seated position
- ☐ Traveling (public transportation)
- ☐ Turning
- ☐ Twisting
- ☐ Typing
- ☐ Using computer
- ☐ Walking
- ☐ OTHER

FOR PEDESTRIAN ACCIDENTS ONLY:

As a pedestrian, what were you (or was the patient) doing at the time of the accident? _____

FOR AUTO ACCIDENTS ONLY:

Were you (or was the patient) wearing a seatbelt? ○ Yes ○ No ○ Don't know Did the airbag deploy? ○ Yes ○ No

Where in the vehicle were you (or was the patient) when the accident happened? _____

What interior vehicle part did you (or the patient) come into contact with? Choose all that apply.

- ☐ No interior parts were contacted at time of accident
- ☐ Airbag
- ☐ Armrest
- ☐ Dashboard
- ☐ Door
- ☐ Flying object(s) inside vehicle
- ☐ Headrest
- ☐ Seat
- ☐ Steering wheel
- ☐ Window
- ☐ Windshield

FOR MOTORCYCLE/BICYCLE ACCIDENTS ONLY:

Where on the vehichle were you (or was the patient) when the accident happened? ○ Operator ○ Passenger

What type of protection did you (or did the patient) have? Choose all that apply.

- ☐ Bicycle helmet
- ☐ Motorcycle Helmet- full face
- ☐ Motorcycle Helmet- open face
- ☐ Motorcycle Helmet- half helmet
- ☐ Protective eyewear
- ☐ Leathers
- ☐ Gloves
- ☐ Boots
- ☐ No protective wear
- ☐ OTHER

What did you (or the patient) come into contact with at the time of the collision? _____

Where were you (or was the patient) looking at the time of impact? _____

Did you (or the patient) come in contact with anything at the time of the collision? ○ Yes ○ No ○ Don't know

What part of your (or the patient's) body made contact? Choose all that apply.

- ☐ None made contact
- ☐ Back of head/neck
- ☐ Front of head
- ☐ Left arm
- ☐ Left chest/flank
- ☐ Left foot
- ☐ Left head
- ☐ Left knee
- ☐ Left leg
- ☐ Left shoulder
- ☐ Right arm
- ☐ Right chest/flank
- ☐ Right foot
- ☐ Right head
- ☐ Right knee
- ☐ Right leg
- ☐ Right shoulder
- ☐ OTHER

Did you (or the patient) receive an injury to the head? ○ Yes ○ No Did you (or the patient) lose consciousness? ○ Yes ○ No

What part of your (or the patient's) vehicle was impacted? Choose all that apply.

- ☐ Front right
- ☐ Front left
- ☐ Front head on
- ☐ Rear right
- ☐ Rear left
- ☐ Rear end
- ☐ Right side (passenger's side)
- ☐ Left side (driver's side)
- ☐ Unknown

In what direction was your (or the patient's) vehicle moving? _____

What was the estimated speed of your (or the patient's) vehicle? _____

What was the extent of the damage to your (or the patient's) vehicle? _____

What was the extent of the damage to the other vehicle? _____

In what direction was the other vehicle moving? _____

Mechanism of Injury (2):

What was the estimated speed of the other vehicle? _____

Was your (or the patient's) vehicle towed from the scene? ◯ Yes ◯ No Did police arrive at the scene? ◯ Yes ◯ No

Did Emergency Medical Services arrive at the scene? ◯ Yes ◯ No Was an accident report taken? ◯ Yes ◯ No

Were you (or was the patient) transported to a medical facility (ER or hospital)? _____

Have you (or has the patient) received any treatment since the accident? Choose all that apply.

- ☐ Admitted
- ☐ Examination was performed
- ☐ Home treatment with cold
- ☐ Home treatment with heat
- ☐ Home treatment with over-the-counter medication
- ☐ Home treatment with rest
- ☐ Medication was prescribed
- ☐ No treatment since accident
- ☐ Physical therapy
- ☐ Referred for further evaluation and treatment
- ☐ Referred to a chiropractor
- ☐ Referred to a neurologists
- ☐ Referred to orthopedists
- ☐ Referred to primary care provider
- ☐ Released
- ☐ Released that day
- ☐ Surgery
- ☐ X-rays were completed
- ☐ OTHER

What was the location of symptoms felt at the time of the accident? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:

☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left upper extremity	☐ Rear of left upper extremity
☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand

Lower Extremity:

☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
☐ OTHER			

Describe the discomfort felt at the time of the accident. Choose all that apply.

- ☐ Aching ☐ Burning ☐ Deep ☐ Diffuse ☐ Dull ☐ Heavy ☐ Numbness ☐ Pulling
- ☐ Sharp ☐ Shock like ☐ Shooting ☐ Stiffness ☐ Throbbing ☐ Tightness ☐ Tingling ☐ OTHER

Are there any additional symptoms which appeared since the accident happened? Choose all that apply.

☐ None	☐ Anxiety	☐ Breathing difficulty	☐ Chest pain	☐ Depression
☐ Disbelief	☐ Dizziness	☐ Exhaustion	☐ Facial pain	☐ Genital pain
☐ Gluteal pain	☐ Headaches	☐ Irritability	☐ Loss of appetite	☐ Low energy
☐ Muscle spasm	☐ Numbness and tingling	☐ Rib pain	☐ Shock	☐ Sleeping difficulty
☐ Soreness	☐ Stomach pain	☐ Stress	☐ Stunned	☐ Tightness
☐ Tiredness	☐ OTHER			

Mechanism of Injury (3):

Describe the status of your symptoms since the accident. Choose all that apply.

- ☐ Deteriorated daily functioning at home/work
- ☐ Disappeared
- ☐ Elicited less stiffness
- ☐ Elicited more stiffness
- ☐ Elicited less pain
- ☐ Elicited more pain
- ☐ Exacerbated
- ☐ Improved
- ☐ Improved daily functioning at home/work
- ☐ Lessened
- ☐ Shown no change in daily functioning at home/work
- ☐ Somewhat resolved
- ☐ Stayed the same
- ☐ Worsened
- ☐ Worsened quality of life
- ☐ OTHER

Review of Systems:

Musculoskeletal - Other than the musculoskeletal complaints you mentioned already, do you have or have you ever had:

- ☐ No additional musculoskeletal complaints
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Joint or muscle pains/stiffness
- ☐ Cramping
- ☐ Swelling, redness deformity of joint(s)
- ☐ Fractures
- ☐ Implants, plates, pins or screws
- ☐ Neck pain
- ☐ Back problems
- ☐ Hip disorders
- ☐ Knee injuries
- ☐ Foot/ankle pain
- ☐ Shoulder problems
- ☐ Elbow/wrist pain
- ☐ Poor posture
- ☐ Gout

Neurological - Other than the neurological complaints you mentioned already, do you have or have you ever had:

- ☐ No additional neurological complaints
- ☐ Anxiety and/or panic
- ☐ Depression
- ☐ Memory issues
- ☐ Sleeping issues
- ☐ Headache
- ☐ Dizziness
- ☐ Weak muscles
- ☐ Pins and needles
- ☐ Numbness
- ☐ Loss of smell or taste
- ☐ Temporary loss of vision, smell or hearing
- ☐ Difficulty concentrating
- ☐ Stroke
- ☐ Epilepsy or seizures

Head, Eyes, Ears, Nose and Throat - Do you have or have you ever had:

- ☐ No complaints
- ☐ Headaches or migraines
- ☐ Eye or vision problems
- ☐ Eyeglasses or contact lenses
- ☐ Eye surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Nose congestion or sinus trouble
- ☐ Ear or hearing problems
- ☐ Dental problems
- ☐ Gum problems
- ☐ TMJ problems
- ☐ Sore throat
- ☐ Postnasal drip
- ☐ Swollen lymph nodes
- ☐ OTHER

Cardiovascular - Do you have or have you ever had:

- ☐ No cardiovascular complaints
- ☐ Chest pain or tightness
- ☐ Palpitations
- ☐ Swollen legs or feet
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congenital heart defects
- ☐ Rheumatic fever
- ☐ Leg pain upon walking
- ☐ Blood clots
- ☐ Varicose veins
- ☐ Dizziness
- ☐ Excessive bruising
- ☐ Coronary artery disease
- ☐ OTHER

Respiratory - Do you have or have you ever had:

- ☐ No respiratory complaints
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Snoring issues
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Blood in sputum
- ☐ Asthma
- ☐ Apnea
- ☐ Emphysema
- ☐ Hay fever
- ☐ OTHER

Gastrointestinal - Do you have or have you ever had:

- ☐ No gastrointestinal complaints
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Bloating
- ☐ Heartburn
- ☐ Ulcer
- ☐ Difficulty swallowing
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Change in bowel habits
- ☐ Black or bloody stool
- ☐ Colon cancer or colon polyps
- ☐ Hemorrhoids
- ☐ Food sensitivities
- ☐ Constipation
- ☐ Severe diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's disease
- ☐ Gastric reflux
- ☐ Collitis
- ☐ OTHER

Genitourinary - Do you have or have you ever had:

- ☐ No genitourinary complaints
- ☐ Painful or frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Urinary infections
- ☐ Sexual dysfunction
- ☐ Incontinence
- ☐ OTHER

Review of Systems (2):

Endocrine - Do you have or have you ever had:

- ☐ No endocrine complaints
- ☐ Feeling hot or cold all the time
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Increase urination
- ☐ Excessive thirst
- ☐ Hyperthyroidism
- ☐ Hyperparathyroidism
- ☐ Testosterone deficiency
- ☐ Cushing's syndrome
- ☐ Steroid treatments
- ☐ OTHER

Dermatological and Bleeding - Do you have or have you ever had:

- ☐ No skin or bleeding complaints
- ☐ Skin trouble or rashes
- ☐ Flushing
- ☐ Change in hair or nails
- ☐ Excessive acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Skin pigmentation issues
- ☐ Blood in stool
- ☐ Easy bruising
- ☐ Gum bleeding
- ☐ OTHER

For Women Only:

Are you pregnant? ○ Yes ○ No

Are you taking birth control? ○ Yes ○ No

Do you take HRT? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Do you experience painful periods? ○ Yes ○ No

Do you have irregular cycles? ○ Yes ○ No

Do you perform a regular self breast examination? ○ Yes ○ No

Do you have breast implants? ○ Yes ○ No

Do you take oral contraceptives? ○ Yes ○ No

Date of last PAP/pelvic exam? _____

Date of last mammogram? _____

Date of Last Menstrual Period? _____

Past, Family and Social History:

List your (or the patient's) past surgical history. Choose all that apply and indicate the year in which the surgeries were performed.

- ☐ Yes, surgical history
- ☐ No surgical history
- ☐ Abdominal aortic aneurysm repair Year ____
- ☐ Appendectomy Year ____
- ☐ Biopsy Year ____
- ☐ Bunionectomy Year ____
- ☐ Cardiac bypass Year ____
- ☐ Cardiac valve replacement Year ____
- ☐ Carpal tunnel - left Year ____
- ☐ Carpal tunnel - right Year ____
- ☐ Cataract - left Year ____
- ☐ Cataract - right Year ____
- ☐ C-section Year ____
- ☐ Cosmetic - face lift Year ____
- ☐ Cosmetic - nose Year ____
- ☐ Cosmetic - breast reduction or enlargement Year ____
- ☐ Cosmetic - tummy tuck Year ____
- ☐ Cosmetic - other Year ____
- ☐ Ear tubes Year ____
- ☐ Gall bladder removed Year ____
- ☐ Gastric bypass Year ____
- ☐ Hysterectomy - complete Year ____
- ☐ Hysterectomy - partial Year ____
- ☐ Knee - left Year ____
- ☐ Knee - right Year ____
- ☐ Lasik Year ____
- ☐ Mastectomy Year ____
- ☐ Shoulder - left Year ____
- ☐ Shoulder - right Year ____
- ☐ Thyroidectomy Year ____
- ☐ Tonsils Year ____
- ☐ Tonsils & adenoids Year ____
- ☐ Wisdom teeth Year ____
- ☐ Discectomy level Year ____
- ☐ Implants Year ____
- ☐ Ganglion cyst Year ____
- ☐ Spinal fusion Year ____
- ☐ Transplant Year ____
- ☐ OTHER Year ____

Describe any past illnesses or conditions the doctor should be aware of and the age at which the illness(es) reportedly occurred.

☐ Yes, past illnesses ☐ No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)

Number of children ____ Number of pregnancies ____ Number of deliveries ____

- ☐ AIDS/HIV Age ____
- ☐ Alcoholism Age ____
- ☐ Alzheimer's Age ____
- ☐ Anemia Age ____
- ☐ Anorexia Age ____
- ☐ Arthritis Age ____
- ☐ Asthma Age ____
- ☐ Bleeding disorders Age ____
- ☐ Breast lump Age ____
- ☐ Bronchitis Age ____
- ☐ Bulimia Age ____
- ☐ Cancer Age ____ Explain _____
- ☐ Chemical dependency Age ____
- ☐ Congenital anomaly Age ____ Explain _____
- ☐ Depression Age ____
- ☐ Diabetes Age ____
- ☐ Emphysema Age ____

Past, Family and Social History (2):

☐ Epilepsy	Age			
☐ Extremity issues	Age		Explain	
☐ Fracture	Age		Explain	
☐ Heart disease	Age			
☐ Hepatitis	Age			
☐ Hereditary disorder	Age		Explain	
☐ Hernia	Age			
☐ Herniated disc	Age			
☐ High blood pressure	Age			
☐ High cholesterol	Age			
☐ Hospitalization	Age		Explain	
☐ Kidney disease	Age			
☐ Liver disease	Age			
☐ Migraine headaches	Age			
☐ Miscarriage	Age			
☐ Multiple sclerosis	Age			
☐ Natural labor	Age			
☐ Neuromuscular issues	Age		Explain	
☐ Osteoarthritis	Age			
☐ Osteoporosis	Age			
☐ Pacemaker	Age			
☐ Parkinson's disease	Age			
☐ Pinched nerve	Age			
☐ Pneumonia	Age			
☐ Polio	Age			
☐ Previous chiropractic care	Age			
☐ Prostate problems	Age			
☐ Psychiatric care	Age			
☐ Rheumatoid arthritis	Age			
☐ Stroke	Age			
☐ Suicide attempt	Age			
☐ Thyroid problems	Age			
☐ Trauma/injury	Age		Explain	
☐ Tumor	Age			
☐ Ulcers	Age			
☐ Vaginal infection	Age			
☐ Venereal disease	Age			
☐ OTHER	Age			

Past, Family and Social History (3):

List any past history of accidents or trauma. Choose all that apply.

- ☐ No previous trauma reported
- ☐ No new trauma reported since initial intake
- ☐ Single automobile accident
- ☐ Multiple automobile accidents
- ☐ Slip and fall
- ☐ Multiple slip and falls
- ☐ Single motorcycle accident
- ☐ Multiple motorcycles accident
- ☐ Single boating accident
- ☐ Multiple boating accidents
- ☐ Resulting in fracture(s)
- ☐ Resulting in permanent injury or disability
- ☐ Resulting in hospitalization(s)
- ☐ Resulting in no significant injury or loss
- ☐ Resulting in sprains/strains
- ☐ Resulting in loss of consciousness
- ☐ Suicide (including attempts)
- ☐ OTHER

Are you presently taking any medication? ○ Yes ○ No

Which of the following medications are you presently taking? Choose all that apply.

- ☐ Over-the-counter
- ☐ Prescription
- ☐ Antidepressant
- ☐ Muscle relaxer
- ☐ Anti-inflammatory (NSAID)
- ☐ Steroidal Anti-inflammatory
- ☐ Antacid
- ☐ Anti-viral
- ☐ Aspirin
- ☐ Chemotherapy
- ☐ Codeine
- ☐ Hallucinogenic
- ☐ Marijuana
- ☐ Mood elevator
- ☐ Sleeping pill
- ☐ Stimulant
- ☐ Tranquilizer
- ☐ OTHER

List your (or the patient's) family health history. Choose all that apply to blood relatives only.

- ☐ No family history of diabetes, cancer, hypertension and progressive neurological disorders.
- ☐ Not applicable, patient was adopted
- ☐ No change in family health history
- ☐ Unknown
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Congenital anomaly
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Extremity issues
- ☐ Fracture
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hereditary disorder
- ☐ Hernia
- ☐ Herniated disc
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hospitalization
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Natural labor
- ☐ Neuromuscular issues
- ☐ Osteoarthritis
- ☐ Trauma/injury
- ☐ OTHER

What are your (or are the patient's) current work habits? Choose all that apply.

- ☐ No change in work habits since condition began
- ☐ Cannot not work due to presenting condition
- ☐ None reported
- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ 0 to 20 hours per week
- ☐ 20 to 40 hours per week
- ☐ 40 to 50 hours per week
- ☐ 50 to 60 hours per week
- ☐ 60 to 70 hours per week
- ☐ Over 70 hours per week
- ☐ Full-time
- ☐ Part-time
- ☐ Homemaker
- ☐ Retired
- ☐ Student
- ☐ Unemployed
- ☐ Mostly sitting
- ☐ Mostly standing
- ☐ Mostly walking
- ☐ Light labor
- ☐ Moderate labor
- ☐ Heavy labor
- ☐ Sedentary
- ☐ Computer
- ☐ Repetitive
- ☐ Telephone
- ☐ Difficult
- ☐ Enjoyable
- ☐ Relaxed
- ☐ Stressful

Past, Family and Social History (4):

How would you describe your (or the patient's) personal social habits? Choose all that apply.

- ☐ No change in social habits since injury
- ☐ Does not smoke, drink alcohol or take recreational drugs
- ☐ A social drinker
- ☐ A light drinker
- ☐ A moderate drinker
- ☐ A heavy drinker
- ☐ An alcoholic
- ☐ A recovering alcoholic
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Ex-smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Never smoked tobacco
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked
- ☐ Does not drink caffeine
- ☐ Drinks 1 cup of caffeine in the morning
- ☐ Drinks 2 to 4 cups of caffeine per day
- ☐ Drinks 5 or more cups of caffeine per day
- ☐ Does not use recreational drugs
- ☐ Light use of recreational drugs
- ☐ Moderate use of recreational drugs
- ☐ Heavy use of recreational drugs
- ☐ Is drug addicted
- ☐ Is a recovering drug addict

How would you describe your (or the patient's) present exercise habits? Choose all that apply.

- ☐ No changes in exercise habits since condition began
- ☐ Daily
- ☐ None
- ☐ Every other day
- ☐ Few times a week
- ☐ Once a week
- ☐ Almost nothing
- ☐ Aerobic
- ☐ Stretching
- ☐ Strength
- ☐ Baseball
- ☐ Basketball
- ☐ Blading
- ☐ Boating
- ☐ Climbing
- ☐ Cycling
- ☐ Football
- ☐ Golf
- ☐ Handball
- ☐ Hang gliding
- ☐ Hiking
- ☐ Ice skating
- ☐ Mountain climbing
- ☐ Ping-Pong
- ☐ Racquetball
- ☐ Running
- ☐ Skiing
- ☐ Skydiving
- ☐ Snowboarding
- ☐ Soccer
- ☐ Surfing
- ☐ Tennis
- ☐ Volleyball
- ☐ Walking
- ☐ Waterskiing
- ☐ Weight training
- ☐ Weight training with a personal trainer
- ☐ Pilates
- ☐ Spinning
- ☐ Step
- ☐ Yoga
- ☐ Zumba

How would you describe your (or the patient's) diet and nutritional status? Choose all that apply.

- ☐ No changes in diet or nutrition since condition began
- ☐ Controlled
- ☐ Out-of-control
- ☐ Restricted
- ☐ Unrestricted
- ☐ 1 to 2 meals a day
- ☐ 2 to 3 meals a day
- ☐ More than 3 meals a day
- ☐ Reports eating too little
- ☐ Reports eating too much
- ☐ Binges
- ☐ Purges
- ☐ Balanced
- ☐ High protein
- ☐ Low carbohydrate
- ☐ Low-fat
- ☐ Low-cholesterol
- ☐ No red meat
- ☐ Atkins
- ☐ Diabetic
- ☐ Gluten free
- ☐ Ideal Protein
- ☐ Jenny Craig
- ☐ Kosher
- ☐ Macrobiotic
- ☐ Paleo
- ☐ Raw food
- ☐ South Beach
- ☐ Vegan
- ☐ Vegetarian
- ☐ Weight Watchers
- ☐ Zone
- ☐ Does not take daily supplements
- ☐ Takes daily supplements
- ☐ OTHER

For Men Only:

Do you have pain or lump in scrotum or testicles? ○ Yes ○ No ○ Unsure

Do you have discharge from your penis? ○ Yes ○ No ○ Unsure

Do you have impaired libido (sex drive)? ○ Yes ○ No ○ Unsure

Do you have prostate problems? ○ Yes ○ No ○ Unsure

When was your last prostate exam? Approximate Date: _____ ☐ Never had one

When was your last PSA (Prostate-Specific Antigen) test? Approximate Date: _____ ☐ Never had one

What was your PSA (Prostate-Specific Antigen) level on your latest test? _____

Patient Social

Alcohol:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Caffeine:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Diet Food Products:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Drugs:	○ Daily	○ Weekly	○ Occasionaly	○ Never
OTC Stimulants:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Exercise:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Homemade Food:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Processed:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Soft Drinks:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Tobacco:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Water:	○ Daily	○ Weekly	○ Occasionaly	○ Never					

Referral Information:

Referring Physician: _____ Referred Patient: _____ Referred by _____

Advertisement: ○ Yes ○ No Advertisement: _____

Referred Directory: ○ Yes ○ No Referred Directory: _____

Chiropractic Experience:

Who referred you to our office: _____

Where did you hear about us? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Mailing ☐ Community Event ☐ Other _____

Have you been adjusted by a chiropractor before? ○ Yes ○ No If yes, Why? _____

Doctor's Name: _____ Approximate Date of Visit _____

Has any member of your family ever seen a wellness chiropractor? ○ Yes ○ No

Employer Information:

Employed: _____ Employer Name _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information:

Payment Name _____ Primary Phone # _____ Primary ID/Policy _____

Payment Address _____

Payment City _____ Payment State _____ Payment Zip _____

Primary Group # _____ Primary Name _____ Primary DOB _____

Secondary Name _____ Secondary Phone # _____ Secondary ID/Policy _____

Secondary Address _____

Secondary City _____ Secondary State _____ Secondary Zip _____

Secondary Group # _____ Secondary Name _____ Secondary DOB _____

Claim # _____ Claim Contact _____ Claim # _____

Attorney Name _____ Attorney Phone # _____

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the Doctor to select the type of care appropriate for my condition

☐ Relief care: Symptomatic relief of pain or discomfort.

☐ Corrective care: Correcting and relieving the cause of the problem as well as the symptom

☐ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ○ Yes ○ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ○ Yes ○ No Planning: ○ Yes ○ No

Medications: _____

Supplements: _____

Were you aware that...

Chiropractic is the largest natural healing profession in the world? ○ Yes ○ No Doctor's of Chiropractic work with the nervous system? ○ Yes ○ No

The nervous system controls all bodily functions and systems? ○ Yes ○ No

EHR Information:

Preferred Language _____ Ethnicity _____ Race _____

Smoking Status _____ Smoking Start Date _____ Tried to quit? ○ Yes ○ No

Type of Tobacco ☐ Cigarettes ☐ Chewing Tobacco ☐ Cigar ☐ Pipe ☐ Other

How much tobacco do you use? _____ How long have you used tobacco? _____

Current Medications And Dosage

Medication Allergies

☐ I choose to decline receipt of my clinical summary after every visit

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date: _____