

# COMPLETE HEALTH & CHIROPRACTIC CENTER

## PATIENT INFORMATION

Title (check one):  Mr.  Mrs.  Ms.  Miss  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F  
Social Security No.: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Marital Status:  Single  Married  Other  
Email: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address Line 1: \_\_\_\_\_  
Address Line 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is your spouse a patient in the clinic?  Yes  No  
Spouse's Name: \_\_\_\_\_  
Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
Is it ok to contact you at work?  Yes  No  
Is it ok to call your cell phone?  Yes  No  
How did you hear about our clinic? Who referred you?  
 Family Member  Attorney  Internet  
 Health Class  Friend  Yellow Pages  
 Billboard  Brochure  Physician  
 Newspaper  Television  Direct Mail  
 Employer/Employee  Radio  Other  
If you selected 'Family member', 'friend' or 'physician' please name:  
\_\_\_\_\_  
If you selected 'other' please describe:  
\_\_\_\_\_

## PHONE INFORMATION

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

### EMERGENCY CONTACT

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Type of accident:  Auto  Work  Home  Other  
To whom have you made a report of your accident?  Auto Insurance  Employer  Worker Comp.  Other  
Attorney Name (if applicable): \_\_\_\_\_  
Auto Insurance Company: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

## MEDICATIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

## ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_

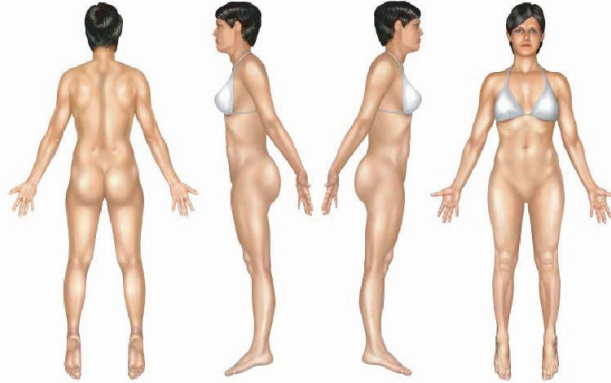
## VITAMINS / MINERALS

\_\_\_\_\_  
\_\_\_\_\_

## SYMPTOM INFORMATION

By using the key below, please indicate on the body diagram where you are experiencing the following symptoms:

- # = Numbness
- X = Burning
- / = Stabbing
- 0 = Pins & Needles
- + = Dull Ache



Describe your symptoms: \_\_\_\_\_

When did your symptoms start? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

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)

What describes the nature of your symptoms?

- Sharp     
  Dull ache     
  Numb     
  Shooting     
  Burning     
  Tingling     
  Stabbing

How are your symptoms changing?

- Getting better     
  Not changing     
  Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms (0 = None to 10 = Unbearable)

- 0 None     
  1     
  2     
  3     
  4     
  5     
  6     
  7     
  8     
  9     
  10 Unbearable

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

- Not at all     
  A little bit     
  Moderately     
  Quite a bit     
  Extremely

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     
  A little of the time     
  None of the time

In general, would you say your overall health right now is...

- Excellent     
  Very good     
  Good     
  Fair     
  Poor

Who have you seen for your symptoms?

- No one     
  Other Chiropractor     
  Medical Doctor     
  Physical Therapist     
  Other

When did you receive this treatment?

- In the last month     
  2-3 months ago     
  3-6 months ago     
  6 months to 1 year ago  
 1-2 years ago     
  2-5 years ago     
  5-10 years ago

What tests have you had for your symptoms?

- X-rays     
  MRI     
  CT Scan     
  Other

When were these tests done?

- In the last month     
  2-3 months ago     
  3-6 months ago     
  6 months to 1 year ago  
 1-2 years ago     
  2-5 years ago     
  5-10 years ago

Have you had similar symptoms in the past?

- Yes     
  No

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

What is your occupation?

- Professional/Executive     
  White Collar/Secretarial     
  Tradesperson     
  Laborer     
  Homemaker  
 Full-time student     
  Retired     
  Other

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

- Full-time     
  Part-time     
  Self-employed     
  Unemployed     
  Off work     
  Other

# REVIEW OF SYMPTOMS

Have you had trouble with any of the following:

**Cardiovascular:** No \_\_\_\_\_

|                     | Present | Past |
|---------------------|---------|------|
| Poor Circulation    |         |      |
| High Blood Pressure |         |      |
| Aortic Aneurism     |         |      |
| Heart Disease       |         |      |
| Heart Attack        |         |      |
| Chest Pain          |         |      |
| High Cholesterol    |         |      |
| Pace Maker          |         |      |
| Jaw Pain            |         |      |
| Irregular Heartbeat |         |      |
| Swelling of Legs    |         |      |

**Genitourinary:** No \_\_\_\_\_

|                    | Present | Past |
|--------------------|---------|------|
| Kidney Disease     |         |      |
| Lower Side Pain    |         |      |
| Buring Urination   |         |      |
| Frequent Urination |         |      |
| Blood in Urine     |         |      |
| Kidney Stone       |         |      |

**Hematologic/Lymphatic: No \_\_\_\_\_**

|                      | Present | Past |
|----------------------|---------|------|
| Hepatitis            |         |      |
| Blood Clots          |         |      |
| Cancer               |         |      |
| Easy Bruising        |         |      |
| Easy Bleeding        |         |      |
| Fevers/Chills/Sweats |         |      |

**Neurologic:** No \_\_\_\_\_

|                     | Present | Past |
|---------------------|---------|------|
| Stroke              |         |      |
| Seizures            |         |      |
| Head Injury         |         |      |
| Brain Aneurysm      |         |      |
| Numbness            |         |      |
| Severe Headaches    |         |      |
| Pinched Nerves      |         |      |
| Parkinson's Disease |         |      |
| Carpal Tunnel       |         |      |
| Spinning/Balance    |         |      |

**Respiratory:** No \_\_\_\_\_

|                     | Present | Past |
|---------------------|---------|------|
| Asthma              |         |      |
| Tuberculsis         |         |      |
| Shortness of Breath |         |      |
| Emphysema           |         |      |
| Cold/Flu            |         |      |
| Cough/Wheezing      |         |      |

**Ears/Nose/Throat:** No \_\_\_\_\_

|                       | Present | Past |
|-----------------------|---------|------|
| Dizziness             |         |      |
| Hearing Loss          |         |      |
| Sinus Infection       |         |      |
| Nosebleed             |         |      |
| Sore Throat           |         |      |
| Difficulty Swallowing |         |      |
| Bleeding Gums         |         |      |

**Eyes:** No \_\_\_\_\_

|                | Present | Past |
|----------------|---------|------|
| Glaucoma       |         |      |
| Double Vision  |         |      |
| Blurred Vision |         |      |

**Integumentary:** No \_\_\_\_\_

|              | Present | Past |
|--------------|---------|------|
| Skin Ulcers  |         |      |
| Skin Disease |         |      |
| Eczema       |         |      |
| Psoriasis    |         |      |
| Rashes       |         |      |

**Psychiatric:** No \_\_\_\_\_

|                  | Present | Past |
|------------------|---------|------|
| Depression       |         |      |
| Anxiety Disorder |         |      |
| Unusual Stress   |         |      |

**Constitutional:** No \_\_\_\_\_

|                      | Present | Past |
|----------------------|---------|------|
| Weight Loss/Gain     |         |      |
| Energy Level Problem |         |      |
| Difficulty Sleeping  |         |      |

**Allergic/Immunologic:** No \_\_\_\_\_

|                 | Present | Past |
|-----------------|---------|------|
| Hives           |         |      |
| Immune Disorder |         |      |
| HIV/AIDS        |         |      |
| Allergy Shots   |         |      |
| Cortisone Use   |         |      |

**Gastrointestinal:** No \_\_\_\_\_

|                      | Present | Past |
|----------------------|---------|------|
| Gallbladder Problems |         |      |
| Bowel Problems       |         |      |
| Constipation         |         |      |
| Liver Problems       |         |      |
| Ulcers               |         |      |
| Diarrhea             |         |      |
| Nausea/Vomiting      |         |      |
| Bloody Stools        |         |      |
| Poor Appetite        |         |      |

**Musculoskeletal:** No \_\_\_\_\_

|                 | Present | Past |
|-----------------|---------|------|
| Gout            |         |      |
| Arthritis       |         |      |
| Joint Stiffness |         |      |
| Muscle Weakness |         |      |
| Osteoporosis    |         |      |
| Broken Bones    |         |      |
| Joints Replaced |         |      |

**Endocrine:** No \_\_\_\_\_

|                    | Present | Past |
|--------------------|---------|------|
| Thyroid Disease    |         |      |
| Diabetes           |         |      |
| Hair Loss          |         |      |
| Menopausal         |         |      |
| Menstrual Problems |         |      |

Are You Pregnant?:  Yes  No      Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Family Physician Name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## INJURY / SURGERY HISTORY

Injuries/Surgeries you have had: (Description)

|               |       |             |
|---------------|-------|-------------|
| Falls         | _____ | Date: _____ |
| Head Injuries | _____ | Date: _____ |
| Broken Bones  | _____ | Date: _____ |
| Dislocations  | _____ | Date: _____ |
| Surgeries     | _____ | Date: _____ |

Exercise:    \_\_\_ None        \_\_\_ Occasionally        \_\_\_ Frequently

## FAMILY HISTORY

Has anyone in your family ever had any of the following? Please specify who:

|                      |         |        |                 |
|----------------------|---------|--------|-----------------|
| Arthritis            | ___ Yes | ___ No | Relation: _____ |
| Cholesterol Problems | ___ Yes | ___ No | Relation: _____ |
| Heart Problems       | ___ Yes | ___ No | Relation: _____ |
| Thyroid Problems     | ___ Yes | ___ No | Relation: _____ |
| Cancer               | ___ Yes | ___ No | Relation: _____ |
| Diabetes             | ___ Yes | ___ No | Relation: _____ |
| High Blood Pressure  | ___ Yes | ___ No | Relation: _____ |
| Stroke               | ___ Yes | ___ No | Relation: _____ |

Do you have any children?

|                          |                           |                           |                      |
|--------------------------|---------------------------|---------------------------|----------------------|
| ___ Male under 6 years   | ___ Male under 10 years   | ___ Male under 19 years   | ___ Male 19+ years   |
| ___ Female under 6 years | ___ Female under 10 years | ___ Female under 19 years | ___ Female 19+ years |

## SOCIAL HISTORY

|                                    |                                  |
|------------------------------------|----------------------------------|
| ___ Caffeine used occasionally     | ___ Caffeine used often          |
| ___ Chew tobacco occasionally      | ___ Chew tobacco often           |
| ___ Drink alcohol occasionally     | ___ Drink alcohol often          |
| ___ Smoke 1 pack or less a day     | ___ Smoke more than 1 pack a day |
| ___ Experience stress occasionally | ___ Experience stress often      |
| ___ Wear seat belts always         | ___ Wear seat belts never        |

## OCCUPATIONAL ACTIVITIES

|                        |                              |                          |                         |                   |
|------------------------|------------------------------|--------------------------|-------------------------|-------------------|
| ___ Administration     | ___ Business owner           | ___ Clerical/secretarial | ___ Computer user       | ___ Construction  |
| ___ Daycare/childcare  | ___ Executive/legal          | ___ Food service         | ___ Health care         | ___ Home services |
| ___ Household          | ___ Manufacturing            | ___ Light manual labor   | ___ Medium manual labor |                   |
| ___ Heavy manual labor | ___ Heavy Equipment operator |                          |                         |                   |

## RECREATIONAL ACTIVITIES

|                  |             |                   |              |              |
|------------------|-------------|-------------------|--------------|--------------|
| ___ Back packing | ___ Biking  | ___ Boating       | ___ Football | ___ Golf     |
| ___ Racketball   | ___ Running | ___ Skiing        | ___ Soccer   | ___ Swimming |
| ___ Tennis       | ___ Walking | ___ Weightlifting |              |              |