

# 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

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

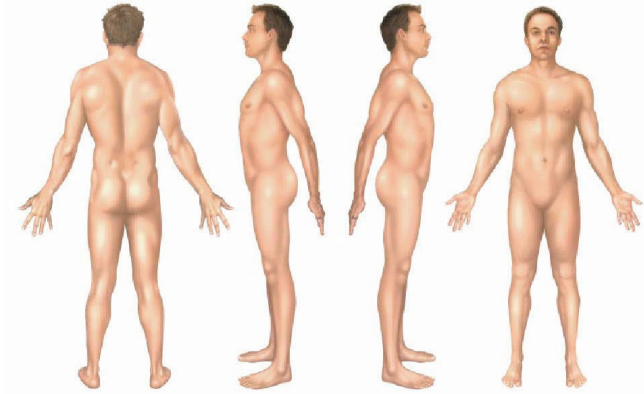
## VITAMINS / MINERALS

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

## 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?

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Constantly<br>(76-100% of the day) | <input type="checkbox"/> Frequently<br>(51-75% of the day) | <input type="checkbox"/> Occasionally<br>(26-50% of the day) | <input type="checkbox"/> Intermittently<br>(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		

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		