



A SPORTS AND FAMILY CHIROPRACTIC CLINIC

PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ MI _____

Street Address _____ City _____

State _____ Zip _____ Sex: (Please Circle One) Male Female

Home Phone(_____) _____ Birthdate _____ Age _____

Work Phone(_____) _____ Soc. Sec. # _____ - _____ - _____

Cell Phone(_____) _____ Employer _____

E-mail Address _____ Occupation _____

Who may we thank for referring you? _____ or Phonebook__ Newspaper__ Flyer/Brochure__ Radio Ad__ Internet__
Drove By__ None of These __

FINANCIAL INFORMATION

Person Responsible for Payment _____ Payment By: (circle one) Cash Credit Card Check Insurance

If paying by insurance, please take your insurance card to the front desk.
If you do not have your card, please fill out the insurance information on the back of this form.

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship to Patient _____

Address _____ Home Phone (_____) _____

Cell Phone (_____) _____ Work Phone (_____) _____ Ext. _____

Signature of Patient or Parent/Legal Guardian _____

Date _____

PATIENT NAME: _____ DATE: _____

1. What brings you into our office today? _____

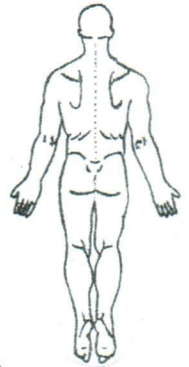
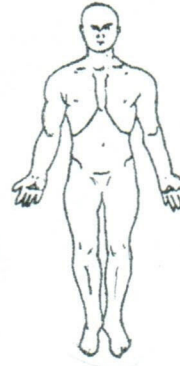
2. What started the pain? Injury /unknown (Please circle) If injury, please describe. _____

3. When did the pain begin? (Approx date) _____

Circle on the diagram the location of pain and / or dysfunction

4. How bad is the pain? NO PAIN UNBEARABLE

At Worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	5	6	7	8	9	10
At Best	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	5	6	7	8	9	10
Currently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	5	6	7	8	9	10



5. Describe the pain: Sharp Shooting Dull Ache

6. Does the pain travel away from specific location? No Yes

If yes, describe where and how: _____ Burning Numb Tingling

7. How bad is the referral pain? Mild Moderate Intense

8. HOW OFTEN DOES THE PAIN OCCUR?

- 1- CONSTANTLY (76-100% OF THE DAY)
- 2- FREQUENTLY (51-75% OF THE DAY)
- 3- OCCASIONALLY (26-50% OF THE DAY)
- 4- INTERMITTENTLY (0-25% OF THE DAY)

9. ARE YOUR SYMPTOMS CHANGING?

- GETTING BETTER COMES AND GOES
- NOT CHANGING GETTING WORSE

10. Have you had any injuries in the past? _____ (If yes, when and describe) _____

11. Have you experienced any associated signs/symptoms such as:

Are there any bowel or bladder changes? Y N If Y How? _____

Do you have breathing difficulties or chest pain? Y N If Y how? _____

Are there any visual or auditory changes? Y N If Y, how? _____

12. Have you seen any other physician for this episode? Y N If Y, who? _____

13. What was the diagnosis & Treatment? _____

14. Have you had these symptoms in the Past? Y N If yes, please describe when and with whom: _____

15. What test(s) have you had for your symptoms? X-rays CT Scan MRI Other None

Results? _____

16. As a result of your symptoms, are you restricted in your ability to perform work exercise Sleep Normal daily activities No

If so, describe _____

(More On Back)

