Patient Name:_____

Street Address: _____

City: _____ **State:** _____**Zip:** _____

Cell Phone: (_____) _____-_____ **Email** _____

Date of Birth: _____/_____/_____ **Sex:** Male/Female **Maritial Status:** _____

Children's name(s)/ Date(s) of birth: _____

_____

Employment Status: Employed Y/N Occupation _____

Student: Y/N School:_____

Emergency Contact Name: _____

Relationship to Patient _____ **Phone** (_____) _____-_____

How did you hear about our office:_____

Medical Conditions: (Circle all that apply to you)

Arthritis Cancer Diabetes Fractures Gout Herniated Disc Heart Disease Hypertension Migranes Osteoporosis Pacemaker Pinched nerve Rheumatoid Arthritis Stroke Thyroid Condition

Surgeries: (Circle all that apply to you)

Appendectomy Cardiovascular procedure Cervical spine Hysterectomy Joint Replacement Prostate Lumbar spine Gall Bladder Brain Shoulder Thoracic spine Knee Carpal Tunnel Gastro-intestinal Uro-genital Hernia Other _____

Social History: (Circle all that apply to you)

Caffeine use: Occasional Often Never **Drink Alcohol:** Occasional Often Never

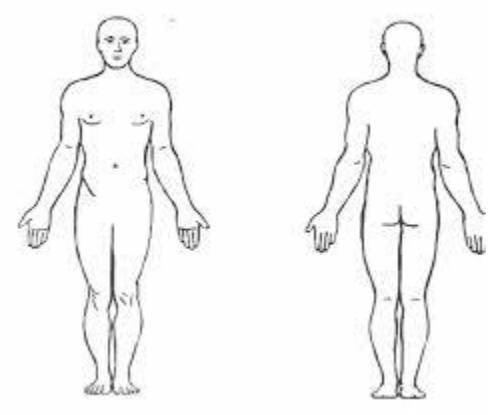
Smoking: Occasional Often Never **Exercise:** Occasional Often Never

Please list all current medications: _____

Vitamins/Supplements: _____

Female patients: **Are you pregnant?** Yes_____ No _____

By using the key below, Mark an **X** on the body diagram where you are experiencing pain.



Circle the type of pain: Numbness Burning Stabbing Tingling Dull Sharp Throbbing Cramps Stiffness Swelling Radiating

On a scale of 1-10 (with 10 being high), rate the severity of your pain:_____

When did your symptoms begin?_____

How often do you experience your symptoms? Constantly Frequently Occasionally

How are your symptoms changing? Getting better Not changing Getting worse

Does your pain interfere with: Work Sleep Daily routine Recreation

Activities that are painful to perform: Sitting Standing Walking Bending Laying Down

What treatment have you already received for your condition: Medications Surgery Physical Therapy Chiropractic Massage Therapy

Are your symptoms a result of a: Motor Vehicle Accident/ Work related Accident

Payment/Insurance Information:

Who is responsible for your bill?_____

Health Insurance Company: _____

Member ID # _____

HIPAA Privacy Practices: I acknowledge that I am aware of HIPPA Privacy Practices

Patient Signature: _____ **Date:** _____