



**CONFIDENTIAL PATIENT INFORMATION**

**Personal Information**

<b>Full name:</b>		<b>Date:</b>	
<b>Address: Street</b>		<b>City</b>	<b>State</b> <b>Zip</b>
<b>Home phone:</b>		<b>Work phone:</b>	
<b>Cell phone:</b>		<b>Email address:</b>	
<b>Date of birth:</b>		<b>Age:</b>	
<b>No. of children:</b>	<b>Ages:</b>	<b>Pregnant?    Yes <input type="checkbox"/>    No <input type="checkbox"/></b>	
<b>Marital status:    M/P   S   W   D</b>	<b>Spouse/Partner/Guardian name:</b>		
<b>Occupation:</b>			
<b>Employer's name &amp; address:</b>			
<b>Spouse's Occupation/Employer:</b>			
<b>Name of person responsible for account:</b>			

**Whom may we thank for referring you?** \_\_\_\_\_

**Have you ever seen a chiropractor before? When?** \_\_\_\_\_

**Addressing What Brought You Into This Office:**

*If you have no symptoms or complaints and are here for Wellness Services, skip to the "General Health History".*

**Health Concerns**

Please list your health concerns according to their severity	Rate of severity 1 – 10 (10 worst)	When did this episode start?	If you had this before, when?	Did problem begin w/ injury?	% of time pain present
1.					
2.					
3.					
4.					

If you have pain: Is it **dull, sharp**? Does it **radiate** (i.e., go down your arms, legs or back)? \_\_\_\_\_

Are there activities that aggravate it? \_\_\_\_\_

Since the problem started is it: About the same?       Getting better?       Getting worse?

Is this condition interfering with any of the following:

<b>Work</b> <input type="checkbox"/>	<b>Sleep</b> <input type="checkbox"/>	<b>Daily routine</b> <input type="checkbox"/>	<b>Sports/exercise</b> <input type="checkbox"/>	<b>Other</b> <input type="checkbox"/> (please explain):
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What have you done about this problem? Was it of benefit? \_\_\_\_\_

**Other practitioners you have seen for this condition:**

\_\_\_\_\_

## General Health History

Have you had any accidents and/or injuries: auto, work-related, or other? (Please include **what** happened, Car accidents, falls, fractures, etc. and **when** it happened).

Have you had any surgery? (Please explain what type and when)

Have you ever had x-rays taken?

Area of body:	When?	Where?
Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes  No

## Past Health History

**Please circle the following conditions you may have had or have now:**

**(+ / current problems, - / past problems):**

Alcoholism	Constipation	Epilepsy	HIV (AIDS)	Nervousness
Allergy	Stomach Problems	Fertility Problems	Irregular Periods	Pneumonia
Anemia	Depression	Gall Bladder Probs	Low Blood Sugar	Polio
Arthritis	Diabetes	Gout	Menstrual Cramps	Ringling in Ears
Asthma	Diarrhea	Headaches	Migraines	Sinus Problems
Back Pain	Eczema	Heart Disease	Multiple Sclerosis	Stroke
Cancer	Lung Problems	High Blood Pressure	Neck Pain	Thyroid Problems

Other (please explain)

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## Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why (prescription and non-prescription):

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Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

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## Exercise

Please list the type of exercise you do on a regular basis

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## Stressors Over Your Lifetime

Please list the top three stresses you have **ever** had in each category; often accumulation of life's stress can lead to health problems and influence our ability to heal.

*Please pay close attention to this as it will help us help you!*

1. Physical stress (falls, accidents, work postures, traumatic birth, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

2. Bio-chemical stress (smoke, unhealthy/fast foods, missed meals, don't drink enough water, drugs/alcohol, sugar etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

**On a scale of 1-10 please grade your present levels of stress (10 is the highest level)**

At work:	At home:	At play:
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Is there anything else which may help us to better understand you that has not been discussed?

I consent to a professional and complete chiropractic examination and to any supplemental examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## OUTCOME ASSESSMENT QUESTIONNAIRE

Name \_\_\_\_\_

On your first visit, please fill out the first column (put today's date on the top row under "Evaluation 1").  
 On each progress exam, we will ask you to fill out the next empty column. This way, along with your physical evaluations, we can track your experience as you progress through your chiropractic care plan.

Health Concerns: Please rate your health concerns on a 0-10 scale; in which 0 is WORST imaginable and 10 is BEST	Start Date:	Evaluation 1 Date:	Evaluation 2 Date:	Evaluation 3 Date:
1				
2				
3				
4				
(NOT FOR FIRST VISIT) Any new health concerns since last evaluation: 0 = worst, 10 = BEST				
1				
2				
I would rate the overall movement and flexibility in my neck 0 = rigid, 10 = flexible,				
I would rate the overall movement and flexibility in my mid back 0 = rigid, 10 = flexible				
I would rate the overall movement and flexibility in my low back 0 = rigid , 10 = flexible,				
My overall posture & ease in standing straight is 0 = terrible , 10 = great,				
I sleep deeply and wake up feeling rested 0 = tired, 10 = rested,				
I feel I have energy for all my daily activities 0 = none, 10 = plenty				
I feel happy/I have more gratitude 0 = none, 10 = plenty				
My ability to take deep breaths is 0 = impossible, 10 = easy				
I notice that I am paying more attention to what my body wants in relation to sleep, rest, exercise, diet since receiving adjustments 0 = no, 10 = yes				
My spiritual connection 0= none, 10 = excellent , NA= not applicable				
My ability to deal with emotional stress is 0 = impossible, 10 = easy				
I would rate my overall feeling of comfort and ease at 0 = severely uncomfortable, 10 = completely comfortable				