

## Patient Information Profile

Please fill in bubbles completely (example:  Yes  No)

**Patient Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Date** \_\_\_\_\_

Payment Source: (please choose one)  Cash  Credit Card  Check

Who referred you to us? \_\_\_\_\_

MD  Chiropractor  Friend  Patient  Yellow Pages  Internet  Attorney  Other

**Reason for your visit today:** \_\_\_\_\_

Date of injury: \_\_\_\_\_ Describe your injury: \_\_\_\_\_

Were you in an accident?  Yes  No (If yes, please choose)  Work  Auto  Other

**List your current medications & doses:** \_\_\_\_\_

**List any medical conditions:** \_\_\_\_\_

**List allergies to medications:** \_\_\_\_\_

**List any previous surgeries & dates:** \_\_\_\_\_

**Other professionals seen for this injury:** MD:  Yes  No Chiropractor:  Yes  No

Massage Therapist:  Yes  No Physical Therapist:  Yes  No

List any previous history of back pain/neck pain: \_\_\_\_\_

Have you had any tests for your **current** condition? (mark all that apply & give date / results)

X-rays:  Yes \_\_\_\_\_  No MRI:  Yes \_\_\_\_\_  No CT scan:  Yes \_\_\_\_\_  No

CT Myelogram:  Yes \_\_\_\_\_  No EMG:  Yes \_\_\_\_\_  No

What treatment have you had for your **current** condition? (mark all that apply & give date / results)

Therapy:  Yes  No Chiropractic:  Yes  No Tens Unit:  Yes  No Injections:  Yes  No

Nerve Blocks/Epidural Steroids:  Yes  No Pain Clinic:  Yes  No Massage Therapy:  Yes  No

Hobbies: \_\_\_\_\_

Attorney: \_\_\_\_\_

### Social History

What is your marital status?  Married  Single  Widowed  Divorced

Do you have children?  Yes  No

Employment:  Full time  Part time  Disability  Retired  Unemployed

Do you smoke?  Yes  No  Quit

Do you drink alcohol?  Yes  No  Socially

Do you have a disability?  Yes  No Describe: \_\_\_\_\_

Do you have a drug history?  Yes  No

### Family History

### Pertinent Family History

Father  Alive  Deceased  Unknown \_\_\_\_\_

Mother  Alive  Deceased  Unknown \_\_\_\_\_

Siblings  Alive  Deceased  Unknown \_\_\_\_\_

Children  Alive  Deceased  Unknown \_\_\_\_\_

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Please fill in bubbles completely (example: ● Yes ○ No)

### Are you having any of these symptoms:

Loss of appetite?	<input type="radio"/> Yes <input type="radio"/> No	Urinary urgency?	<input type="radio"/> Yes <input type="radio"/> No
Fevers?	<input type="radio"/> Yes <input type="radio"/> No	Frequent urination?	<input type="radio"/> Yes <input type="radio"/> No
Weakness?	<input type="radio"/> Yes <input type="radio"/> No	Loss of bladder control?	<input type="radio"/> Yes <input type="radio"/> No
Recent weight loss?	<input type="radio"/> Yes <input type="radio"/> No	Up at night to urinate?	<input type="radio"/> Yes <input type="radio"/> No
Night sweats?	<input type="radio"/> Yes <input type="radio"/> No	Feeling very tired?	<input type="radio"/> Yes <input type="radio"/> No
Weight gain?	<input type="radio"/> Yes <input type="radio"/> No	A high level of stress?	<input type="radio"/> Yes <input type="radio"/> No
Joint swelling?	<input type="radio"/> Yes <input type="radio"/> No	Depression?	<input type="radio"/> Yes <input type="radio"/> No
Joint pain?	<input type="radio"/> Yes <input type="radio"/> No	Difficulty staying asleep?	<input type="radio"/> Yes <input type="radio"/> No
Joint stiffness?	<input type="radio"/> Yes <input type="radio"/> No	Anxiety?	<input type="radio"/> Yes <input type="radio"/> No
Pain in your legs?	<input type="radio"/> Yes <input type="radio"/> No	Nausea?	<input type="radio"/> Yes <input type="radio"/> No
Pain in your arms?	<input type="radio"/> Yes <input type="radio"/> No	Heartburn?	<input type="radio"/> Yes <input type="radio"/> No
Neck pain?	<input type="radio"/> Yes <input type="radio"/> No	Loss of bowel control?	<input type="radio"/> Yes <input type="radio"/> No
General "all over" muscle pain?	<input type="radio"/> Yes <input type="radio"/> No	Constipation?	<input type="radio"/> Yes <input type="radio"/> No
Low back pain?	<input type="radio"/> Yes <input type="radio"/> No	Diarrhea?	<input type="radio"/> Yes <input type="radio"/> No
Mid back pain?	<input type="radio"/> Yes <input type="radio"/> No	Rash?	<input type="radio"/> Yes <input type="radio"/> No
Headaches?	<input type="radio"/> Yes <input type="radio"/> No	Hives?	<input type="radio"/> Yes <input type="radio"/> No
Numbness or tingling?	<input type="radio"/> Yes <input type="radio"/> No	Chest pain?	<input type="radio"/> Yes <input type="radio"/> No
Difficulty falling asleep?	<input type="radio"/> Yes <input type="radio"/> No	Leg swelling?	<input type="radio"/> Yes <input type="radio"/> No
Dizziness?	<input type="radio"/> Yes <input type="radio"/> No	Shortness of breath?	<input type="radio"/> Yes <input type="radio"/> No
Difficulty walking?	<input type="radio"/> Yes <input type="radio"/> No	Palpitations?	<input type="radio"/> Yes <input type="radio"/> No
Difficulty urinating?	<input type="radio"/> Yes <input type="radio"/> No	Blurring of vision?	<input type="radio"/> Yes <input type="radio"/> No
Blood in your urine?	<input type="radio"/> Yes <input type="radio"/> No	Coughing?	<input type="radio"/> Yes <input type="radio"/> No
		ringing in your ears?	<input type="radio"/> Yes <input type="radio"/> No

During your visit with your physician today, what two questions would you like to have answered?

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_