Patient Information Profile

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

Patient Name ____ **Age** _______ **Date** ___________

Payment Source: (please choose one) O Cash O Credit Card O Check O Worker's Comp

Who referred you to us?

O MD O Chiropractor O Friend O Patient O Attorney ___________________________________

O Internet: ______________________________ O Other: _______________________________

Reason for your visit today: ____

Date of injury: __________ Describe your injury: [ ]

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

Complaints (pain location, intensity, radiation): [ ]

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: O Yes O No Chiropractor: O Yes O No

Surgeon: O Yes O No Physical Therapist: O Yes O No

List any previous history of back pain/neck pain: ____

Have you had any tests for your **current** condition? (Mark all that apply. If Yes, give Date (MM/YY) and Results)

X-rays:	O Yes	O No	Date: ______	Results: ___________________________
MRI:	O Yes	O No	Date: ______	Results: ___________________________
CT scan:	O Yes	O No	Date: ______	Results: ___________________________
CT Myelogram:	O Yes	O No	Date: ______	Results: ___________________________
EMG:	O Yes	O No	Date: ______	Results: ___________________________

What treatment have you had for your **current** condition? (Mark all that apply. If Yes, give Date (MM/YY) and Results)

Therapy:	O Yes	O No	Date: ______	Results: ___________________________
Chiropractic:	O Yes	O No	Date: ______	Results: ___________________________
Tens Unit:	O Yes	O No	Date: ______	Results: ___________________________
Injections:	O Yes	O No	Date: ______	Results: ___________________________
Nerve Blocks / Epidural Steroids:	O Yes	O No	Date: ______	Results: ___________________________
Pain Clinic:	O Yes	O No	Date: ______	Results: ___________________________
Massage Therapy:	O Yes	O No	Date: ______	Results: ___________________________
Surgery:	O Yes	O No	Date: ______	Results: ___________________________

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Please fill in bubbles completely (example ● Yes O 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	__________________

Are you having any of these symptoms:

Fevers?	Yes	No	Wheezing?	Yes	No
Weakness?	Yes	No	Poor appetite?	Yes	No
Recent weight loss?	Yes	No	Nausea?	Yes	No
Night sweats?	Yes	No	Heartburn?	Yes	No
Weight gain?	Yes	No	Loss of bowel control?	Yes	No
Feeling very tired?	Yes	No	Constipation?	Yes	No
Difficulty falling asleep?	Yes	No	Diarrhea?	Yes	No
Difficulty staying asleep?	Yes	No	Difficulty urinating?	Yes	No
Joint swelling?	Yes	No	Blood in your urine?	Yes	No
Joint pain?	Yes	No	Urinary urgency?	Yes	No
Joint stiffness?	Yes	No	Frequent urination?	Yes	No
Pain in your legs?	Yes	No	Loss of bladder control?	Yes	No
Pain in your arms?	Yes	No	Up at night to urinate?	Yes	No
Neck pain?	Yes	No	Anxiety?	Yes	No
General “all over” muscle pain?			Depression?	Yes	No
	Yes	No	A high level of stress?	Yes	No
Low back pain?	Yes	No	Nervousness?	Yes	No
Mid back pain?	Yes	No	Emotional problems?	Yes	No
Difficulty walking?	Yes	No	Lack of concentration?	Yes	No
Leg swelling?	Yes	No	Convulsions?	Yes	No
Headaches?	Yes	No	Tremors?	Yes	No
Dizziness?	Yes	No	Paralysis?	Yes	No
Nose bleeds?	Yes	No	Lack of coordination?	Yes	No
Ringing in your ears?	Yes	No	Disorientation?	Yes	No
Chest pain?	Yes	No	Blurring of vision?	Yes	No
Shortness of breath?	Yes	No	Numbness & tingling in extremities?		
Palpitations?	Yes	No		Yes	No
Irregular heart beat?	Yes	No	Anemia?	Yes	No
High blood pressure?	Yes	No	Easy bruising?	Yes	No
Fainting?	Yes	No	Bleeding tendency?	Yes	No
Cough?	Yes	No	Rash?	Yes	No
Coughing blood?	Yes	No	Hives?	Yes	No
Respiratory infections?	Yes	No	Reactions to drugs?	Yes	No
Tuberculosis?	Yes	No			
History of bronchitis or pneumonia?					
	Yes	No			

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

1.____

2.____

Patient Information Profile

- PAIN DIAGRAM -

Patient Name: ____ Date: __________

1. Please mark the body diagrams where you are experiencing pain.

Back

Front

Left Right Right Left

2. For each location marked, please indicate in the table below, the Type of Pain and the Pain Intensity.

Types of Pain include:

- Aching
- Burning
- Cramps
- Dull
- Numbness
- Sharp
- Shooting
- Stabbing
- Stiffness
- Swelling
- Throbbing
- Tingling
- Other

Pain Intensity: Use a scale from 0 (no pain) to 10 (severe pain).

Pain Location	**Type of Pain**	**Pain Intensity** (0 – 10)