

PATIENT # _____

DATE ___ / ___ / ___

CONFIDENTIAL CLINICAL RECORD

GENERAL INFORMATION - PLEASE PRINT

PATIENT NAME _____ HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ HOW LONG? _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION _____

BIRTHDATE ___ / ___ / ___ SEX: M ___ F ___ MARITAL STATUS: M ___ S ___ D ___ W ___ CHILDREN _____

YOUR EMPLOYER _____ CITY _____ YEARS WITH FIRM _____

PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT ADDRESS

PREVIOUS ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SPOUSE'S NAME _____ BIRTHDATE ___ / ___ / ___

SPOUSE'S EMPLOYER _____ CITY _____ HOW LONG? _____

NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

PHYSICIAN _____ DATE OF LAST PHYSICAL ___ / ___ / ___

DENTIST _____ DATE OF LAST VISIT ___ / ___ / ___

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

WHO MAY WE CONTACT IN CASE OF EMERGENCY? _____

PHONE _____ HOW OR WHO REFERRED YOU TO OFFICE? _____

IF YOU ARE IN PAIN, PLEASE MARK AN "X" AT THE EXACT LOCATION(S) OF YOUR PAIN ON THE DIAGRAM BELOW. ALSO, IS YOUR PAIN DULL, SHARP, NUMB, BURNING, TINGLING, ACHY?

MAJOR COMPLAINT

DESCRIBE IN YOUR OWN WORDS YOUR PROBLEM AND HOW IT STARTED. _____

WHEN DID YOUR SYMPTOMS APPEAR? _____

EVER HAD THIS PROBLEM OR SIMILAR PROBLEM BEFORE?
NO ___ YES ___ EXPLAIN: _____

HAVE YOU EVER RECEIVED ANY TREATMENT FOR THIS CONDITION? _____ IF YES, WHEN, WHERE AND WHAT WERE THE RESULTS? _____

IS THE CONDITION PROGRESSIVELY GETTING:
BETTER ___ WORSE ___ THE SAME ___

WHAT MAKES IT BETTER? _____

WHAT MAKES IT WORSE? _____

The diagram includes four human figures: a full-body front view, a full-body back view, a profile view of a head facing right, and a profile view of a head facing left. Below these figures is a horizontal line representing a pain scale from 0 to 10. Under '0' is the text 'NO PAIN' and under '10' is 'WORST PAIN'. The words 'PAIN SCALE' are centered below the scale line.

PLEASE COMPLETE REVERSE SIDE

HOW HAS THIS PROBLEM INTERFERED WITH YOUR LIFE:

- A. HOME _____
- B. WORK _____
- C. RECREATION _____
- D. REST & SLEEP _____

PAST HISTORY

HAVE YOU EVER BEEN INVOLVED IN ANY PREVIOUS ACCIDENTS OR INJURIES OF ANY KIND?

NO __, YES __ -GIVE DATES AND DETAILS: _____

HAVE YOU EVER BEEN PREVIOUSLY TREATED FOR NECK AND/OR BACK PROBLEM? PLEASE EXPLAIN:

HAVE YOU BEEN PREVIOUSLY TREATED BY A DOCTOR OF CHIROPRACTIC? PLEASE EXPLAIN:

PAST SURGICAL HISTORY

HAVE YOU HAD ANY SIGNIFICANT MEDICAL PROBLEMS? (DIABETES; HEART; LUNGS; HIGH BLOOD PRESSURE; BROKEN BONES; CANCER; ETC.)

HAVE ANY OF YOUR BLOOD RELATIVES HAD? (DIABETES; HEART; LUNGS; HIGH BLOOD PRESSURE; CANCER; ETC.)

DID YOU ENJOY GOOD HEALTH PRIOR TO THIS CONDITION?

YES __, NO __ - EXPLAIN: _____

LIST ALL MEDICATIONS, VITAMINS AND/OR HERBS YOUR ARE PRESENTLY TAKING: _____

FOR WOMEN ONLY: DATE OF LAST PERIOD: ___ / ___ / ___ ARE YOU PREGNANT? YES ___; NO ___

SIGNATURE: _____
PATIENT/GUARDIAN

DOCTORS INITIALS: _____