

# Patient Introduction

*Please answer the following questions completely*

Date \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Best place to reach you  Home  Work  Cell Phone (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Sex M F Marital Status S M D W Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Describe Chief Complaint \_\_\_\_\_

Have you had chiropractic care before  Yes  No

Is it possible you are pregnant?  Yes  No

Are you here because of:  Auto Accident?  On the job injury?

Do you have health insurance?  Yes  No

Are you on Medicare  Yes  No

If yes, date injured: \_\_\_\_\_

Do you have an attorney?  Yes  No

Date of last physical exam? \_\_\_\_\_ Reason: \_\_\_\_\_

**Please list all accidents, falls, injuries, surgeries and major illnesses**

Type	Date	Describe / Comments

**Please list any medications / supplements you are presently taking**

Name of Drug / Supplement	Amount	Describe / Comments

**PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Head feels too heavy    | <input type="checkbox"/> Heart Pain          | <input type="checkbox"/> Indigestion            |
| <input type="checkbox"/> Shooting head pains    | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Heart Palpation     | <input type="checkbox"/> Intestinal Gas         |
| <input type="checkbox"/> Sinus Pain             | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Mid-back Pain       | <input type="checkbox"/> Low Back Pain          |
| <input type="checkbox"/> Loss of Smell          | <input type="checkbox"/> Loss of Balance         | <input type="checkbox"/> Heart Attacks       | <input type="checkbox"/> Menstrual Cramps       |
| <input type="checkbox"/> Loss of Taste          | <input type="checkbox"/> Muscle spasms in neck   | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Tightness              | <input type="checkbox"/> Grating in neck         | <input type="checkbox"/> Nervous Stomach     | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Inflammation in throat | <input type="checkbox"/> Tight shoulder muscle   | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Swelling               |
| <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Neuritis arms/shoulders | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Twitching of Face      | <input type="checkbox"/> Arms/hand pain          | <input type="checkbox"/> Cold Sweats         | <input type="checkbox"/> Pinched Nerve          |
| <input type="checkbox"/> Loss of Memory         | <input type="checkbox"/> Cold hands              | <input type="checkbox"/> Liver Trouble       | <input type="checkbox"/> Irregular Sleep        |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Chest Pains             | <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Leg/Feet Pain          |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Shortness of Breath     |  | <input type="checkbox"/> Neck Pain              |

Are any of your family members experiencing any of the above difficulties?

Family Members: \_\_\_\_\_ Difficulties: \_\_\_\_\_