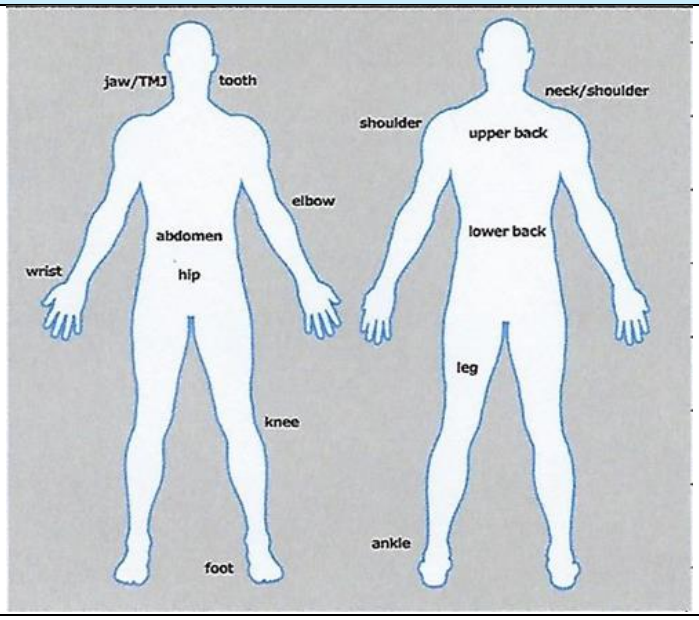
Patient Information Form

Today's Date:	Date of Birth:		
Name:	☐ Male ☐ Female	Age:	☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Other _____
Address:	City:	State:	Zip:
Email:	Cell Phone:	Home Phone:	
Spouse's Name:	Ages of Children:	Occupation/Job Title:	
Employer/Business Name:	Business Address:	Business Phone:	
Type of Work:	How Did You Hear About Us?		
Emergency Contact:	Relationship:	Phone #:	

CURRENT HEALTH CONDITION



Please circle areas of discomfort

Chief Complaint: (why are you here today?)

Body Area Involved: ☐ Cervical (neck) ☐ Upper Extremity (arms, wrist, hands) ☐ Spine (mid-back), ribs, pelvis (low-back) ☐ Lower Expremity (legs, feet, toes)

Condition: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Mechanism of Onset: ☐ Auto ☐ Work ☐ Sports Injury ☐ Unknown ☐ Slip or Fall ☐ Other ☐ Slept Wrong ☐ No injury ☐ Repetitive motion ☐ Over exertion

Symptoms: ☐ Pain ☐ Stiffness ☐ Numbness ☐ Weakness

Location: ☐ Left ☐ Bilateral ☐ Right

Quality: ☐ Burning ☐ Dull/Aching ☐ Sharp ☐ Stabbing ☐ Tightness ☐ Radiating ☐ Diffuse ☐ Localized ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Other _____

On a scale of 0-10, (10 being the worst) Rate your symptoms (Resting):	0	1	2	3	4	5	6	7	8	9	10

On a scale of 0-10, (10 being the worst) Rate your symptoms (with Activity):	0	1	2	3	4	5	6	7	8	9	10

Duration: Symptom(s) Started:

Symptom(s) Worsened:

Symptom(s) Last Occurred:

Injury Occurred:

Accident Occurred:

Timing Worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ W/Activity ☐ Constant ☐ Intermittent

Associated Signs & Symptoms: ☐ Blurred Vision ☐ Headaches ☐ Nausea ☐ Sleep Disturbance ☐ Vision Problems ☐ Irritability ☐ Mood Swings ☐ Stiffness ☐ Depression ☐ Radiating ☐ Localized Tingling ☐ Ringing in Ears ☐ Dizziness

Quality of Headaches: ☐ Dull ☐ Sharp ☐ Aura ☐ Stabbing ☐ Throbbing ☐ No Aura

☐ Radiation: ☐ Left ☐ Right ☐ Bilateral
☐ Weakness: ☐ Left ☐ Right ☐ Bilateral

Other Assoc. Signs & Symptoms: ☐ Aches ☐ Fever ☐ Numbness ☐ Runny Nose ☐ Tingling ☐ Cold Limb ☐ Heartburn ☐ Pale Bluish Skin ☐ Stiffness ☐ Vomiting ☐ Dizziness ☐ Muscle Spasm ☐ Panic ☐ Sweating ☐ Weakness ☐ Fatigue ☐ Nausea ☐ Pins & Needles ☐ Swelling

Modifying Factors – Symptoms Better With: ☐ Activity ☐ Cold ☐ Massage ☐ OTC Meds ☐ Rest ☐ Sitting ☐ Twisting ☐ Bending ☐ Heat ☐ Movement ☐ RX Meds ☐ Stretching ☐ Standing ☐ Walking ☐ Nothing Helps

EMPLOYMENT

Occupation:

Work (hrs/day):

Job Classification: ☐ Sitting ☐ Light ☐ Moderate ☐ Heavy Lifting

Lifting Frequency: ☐ Constant (66-100% day) ☐ Frequent (33-65% day) ☐ Occasional (0-32% day)

Work Activity Postures: (hrs/day) ☐ Sitting ☐ Walking ☐ Pushing ☐ Kneeling ☐ Twisting ☐ Standing ☐ Climbing ☐ Pulling ☐ Reaching ☐ Bending

Repetitive Activities (hrs/day): ☐ Computer ☐ Machinery ☐ Assembly ☐ Phone ☐ Hand Tools ☐ Grasping

How Does This Condition Effect Job Performance?:
☐ Mild Painful (Can Do) ☐ Severe (Unable to Do)
☐ Moderate Painful (Limited) ☐ Other (Explain)

DAILY ACTIVITIES: ON A SCALE OF 0-10, TO WHAT LEVEL ARE YOU EXPERIENCING SYMPTOMS WHILE PERFORMING THESE ACTIVITES											
Activity (Check applicable column)	**0 No Effect**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 Unable to do**
Bending:											
Carrying Things:											
Change Pos. -Sit-Stand:											
Climb Stairs:											
Driving											
Extended Computer Use:											
Eating:											
Exercise:											
Housework:											
Kneeling:											
Lifting:											
Lying Down:											
Reading (Concentration):											
Self Care:											
Sexual Activities:											
Sleep:											
Sitting:											
Sports/Running:											
Standing:											
Stress:											
Stretching:											
Walking:											
Yard Work:											

BELOW IS A LIST OF DISEASES THAT MAY SEEM UNRELATED TO THE PURPOSE OF YOU'RE APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE. REVIEW OF SYMPTOMS-PLEASE FILL OUT ALL OF THE SECTIONS, EVEN IF DENY

Constitutional:
☐ I deny any const. issue(s)
☐ Chills ☐ Weight Gain ☐ Fatigue ☐ Daytime Drowsiness
☐ Night sweats ☐ Weight Loss ☐ Fever

Eye/Vision:
☐ I deny any eye/vision issue(s)
☐ Blindness ☐ Eye Pain ☐ Tearing ☐ Field Cuts ☐ Cataracts ☐ Change in vision
☐ Double Vision ☐ Photophobia ☐ Blurred Vision ☐ Glaucoma ☐ Itching
☐ Wear glasses and/or contact lenses

Ears, Nose, & Throat:
☐ I deny any E/N/T issue(s
☐ Bleeding ☐ Fainting ☐ Nasal Congestion ☐ Rhinorrhea (runny nose)
☐ Discharge ☐ Dizziness ☐ Snoring ☐ Headaches ☐ Loss of smell
☐ Sore throat (frequent) ☐ Sinus infections (frequent) ☐ Dental implants
☐ Ear infections ☐ Hearing loss ☐ Tinnitus (ringing in ears) ☐ Difficulty swallowing
☐ Ear pain ☐ Post nasal drip ☐ Hoarseness ☐ TMJ Problems

Respiration:
☐ I deny any respiratory issue(s)
☐ Asthma ☐ Coughing up blood ☐ Sputum production ☐ Shortness of breath
☐ Cough ☐ Wheezing

Allergy: ☐ Anaphylaxis (history of sneezing) ☐ Food intolerance ☐ Nasal congestion
☐ I deny any allergy issue(s) ☐ Itching

Cardiovascular: ☐ Angina (chest pain/discomfort) ☐ Claudication (leg pain/achiness) ☐ Ulcers
☐ I deny any cardio issue(s) ☐ Heart murmur ☐ Heart problems ☐ Swelling of legs ☐ Varicose veins
☐ Orthopnea (difficulty breathing while laying down)
☐ Palpitations (irregular or forceful breathing)
☐ Paroxysmal (waking up at night with shortness of breath)

Gastrointestinal: ☐ Abdominal pain ☐ Diarrhea ☐ Indigestion ☐ Jaundice (yellowing of skin)
☐ I deny any GI issue(s) ☐ Difficulty swallowing ☐ Belching ☐ Abnormal stool caliber (quality)
☐ Abnormal stool color ☐ Vomiting blood ☐ Vomiting ☐ Constipation
☐ Black, tarry stools ☐ Heartburn ☐ Hemorrhoids ☐ Rectal bleeding
☐ Nausea ☐ Abnormal stool consistency

Female: ☐ Birth Control ☐ Burning urination ☐ Cramps ☐ Frequent urination
☐ I deny any female issue(s) ☐ Breast lump/pain ☐ Hormone therapy ☐ Irregular menstruation
☐ Urine retention ☐ Vaginal bleeding ☐ Vaginal discharge

Male: ☐ Burning urination ☐ Erectile dysfunction ☐ Prostrate problems
☐ I deny any male issue(s) ☐ Frequent urination ☐ Urination retention ☐ Hesitancy/dribbling

Endocrine: ☐ Cold intolerance ☐ Diabetes ☐ Excessive appetite ☐ Excessive hunger
☐ I deny any endocrine issue(s) ☐ Excessive thirst ☐ Goiter ☐ Hair loss ☐ Heat intolerance
☐ Voice changes ☐ Unusal hair growth

Skin: ☐ Changes in nail texture ☐ Changes in skin color ☐ Hives ☐ Itching
☐ I deny any skin issue(s) ☐ Paresthesia (numbness, prickling, tingling) ☐ Rash ☐ Skin lesions/ulcers
☐ Varicosities ☐ History of skin disorders

Nervous Systems: ☐ Dizziness ☐ Headaches ☐ Loss of consciousness ☐ Numbness
☐ I deny any NS issue(s) ☐ Sleep disturbance ☐ Strokes ☐ Unsteadiness of gait ☐ Tremors
☐ Facial weaknes ☐ Limb weakness ☐ Loss of memory ☐ Seizures ☐ Stress

Psychological: ☐ Anhedonia (inability to experience or enjoy life) ☐ Bipolar disorder
☐ I deny any psych issue(s) ☐ Anxiety ☐ Appetite changes ☐ Behavioural changes ☐ Confusion
☐ Convulsions ☐ Depression ☐ Insomia ☐ Memory loss ☐ Mood changes

Hematology: ☐ Anemia ☐ Blood clotting ☐ Bruises easily ☐ Lymph node swelling
☐ I deny any hematology issue(s) ☐ Bleeding ☐ Blood transfusion(s) ☐ Fatigue

PAST HEALTH HISTORY – PLEASE FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE

Adult Illnesses:
☐ I deny any adult illness(es)
☐ Alzheimers ☐ CVA (stroke) ☐ Fibromyalgia ☐ Multiple sclerosis
☐ Anemia ☐ Cystic Kidney Disease ☐ Heart Disease ☐ Pleurisy
☐ Arthritis ☐ Depression ☐ Hepatitis ☐ Psychiatric problems
☐ Asthma ☐ Diabetes (insulin) ☐ Hypertension ☐ Scoliosis
☐ Cancer ☐ Diabetes (non insulin) ☐ Influenza/Pneumonia
☐ Chicken pox ☐ Ear infections (frequent) ☐ Liver disease ☐ HIV
☐ Chron's/Colitis ☐ Emphysema ☐ Lung disease ☐ Shingles
☐ CRPS (RSD) ☐ Eye problems ☐ Lupus erythema (discoid)
☐ Parkinson's Disease ☐ Seizures ☐ Lupus erythema (systemic)
☐ Vertigo ☐ Suicide attempt(s) ☐ STD's (unspecified) ☐ Thyroid problems
☐ Past history of similar symptoms to your current condition

Surgeries:
☐ I deny any surgery(ies)
☐ Angioplasty ☐ Appendectomy ☐ Caesarean Section ☐ Dental surgery
☐ Cardiac catheterization ☐ Carpal tunnel repair ☐ Coronary artery bypass
☐ Cosmetic ☐ D & C ☐ Gall bladder ☐ Hemorrhoidectomy
☐ Hernia repair ☐ Hysterectomy ☐ Joint reconstruction ☐ Spinal fusion
☐ Joint replacement ☐ Laminectomy ☐ Mastectomy ☐ Rotator cuff
☐ Pacemaker insertion ☐ Tonsillectomy ☐ Other: _____

OB/GYN: ☐ I deny OB/GYN issue(s)	☐ I have never been pregnant ☐ I have been pregnant in the past ☐ I am currently pregnant	**Menstrual History:** ☐ My menses is regular Age of onset _____ ☐ My menses is irregular ☐ I am currently in menopause Date of last menses: ____/____/_____
Injuries: ☐ I deny any injury(ies)	☐ Back injury ☐ Fracture ☐ Disability ☐ Head injury ☐ Industrial accident ☐ Broken bones ☐ Joint injury ☐ Severe laceration ☐ Severe soft tissue injury ☐ Severe fall ☐ Motor vehicle accident ☐ Mild/Moderate soft tissue injury	

PLEASE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Precision Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Precision Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my child's care or treatment, any fees for professional services rendered to me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my child's condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees by this office.

Guardian or spouse's signature of authorizing care: (signature indicates consent to treat)	Date:

Patient (print name):	Patient's Signature:	Date: