

Patient Introduction Card

Today's Date _____ Account # _____

Full Legal Name _____ Prefer To Be Called _____

Home Address _____ Occupation _____

City _____ State _____ Zip _____ Employer _____

Home Phone _____ Name of Insurance Co _____

Cell Phone _____ Are you the policyholder? YES NO

Work Phone _____ Primary Care Doctor _____

Email _____ Previous Chiropractic Care? YES NO

Date of Birth _____ Age _____ Major Complaint Today _____

Married Single Other _____

Social Security # _____

Who (or what source) referred you to our office? _____

It is Usual and Customary to pay for Services as Rendered Unless Otherwise Arranged

Patient Health Questionnaire

Patient Name _____ Date _____

1. Describe your current symptoms (Begin with what bothers you the most): _____

2. Do your symptoms radiate (travel)? Yes No If yes, to what part of your body? _____

3. How long have your symptoms been present? _____

4. When are is it most noticeable? Upon Waking During the day Afternoon Evening While Trying to sleep

5. What activities make your symptoms worse? Ice Rest Sitting Medication
 Heat Activity Standing Other _____

6. What activities make your symptoms better? Ice Rest Sitting Medication
 Heat Activity Standing Other _____

7. What describes the nature of your symptoms?

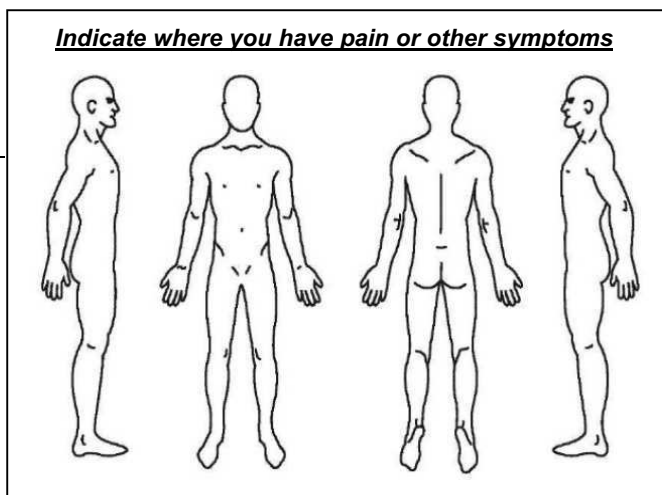
- Sharp Shooting
 Dull Ache Burning
 Numb Tingling

8. How often are your symptoms present?

- Occasional (0-25%) Frequent (50-75%)
 Intermittent (25-50%) Constant (75-100%)

9. How are your symptoms changing?

- Getting Better
 Not Changing
 Getting Worse



10. Who else have you seen for your current symptoms?

- No One Medical Doctor This Office
Provider's name: _____ Other Chiropractor Physical Therapist Other: _____

11. What tests have you had for your symptoms?

- None MRI date: _____
 X-rays date : _____ CT Scan date: _____

12. What describes the severity of your symptoms? None 1 2 3 4 5 6 7 8 9 10 Severe

13. What other forms of care have you tried for your current complaint?

- Nothing Muscle Relaxer Advil / Tylenol / Aleve (circle) Injections
 Pain Medication Ice / Heat (circle) Physical Therapy Other _____

14. What do you feel caused your symptoms?

- Fall Lifting Work
 Car Accident Don't Know Other: _____

15. What activities are affected by your symptoms?

- Work/School Sleeping Driving/Riding in Car Golf Exercising
 Walking Running House Work Yard Work Other _____

For each of the conditions listed below, place a check in the **PAST** column if you have had the condition in the **past**.

Place a check in the **PRESENT** column if you **currently** have the conditions listed.

Many of the following conditions respond to chiropractic and acupuncture

16.	17.		PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
()	()	Headaches	()	()	High Blood Pressure	()	()	Diabetes	()	()
()	()	Neck Pain	()	()	Low Blood Pressure	()	()	Excessive Thirst	()	()
()	()	Upper Back Pain	()	()	High Cholesterol	()	()	Excessive Urination	()	()
()	()	Mid Back Pain	()	()	Heart Attack	()	()	Hypo-Thyroid	()	()
()	()	Low Back Pain	()	()	Chest Pains	()	()	Hyper-Thyroid	()	()
()	()	Shoulder Pain	()	()	Stroke	()	()	Smoking/Tobacco Use	()	()
()	()	Elbow Pain	()	()	Angina	()	()	Drug Dependence	()	()
()	()	Wrist Pain	()	()	Kidney Stones	()	()	Alcohol Dependence	()	()
()	()	Hand Pain	()	()	Kidney Disorder	()	()	Food Allergies	()	()
()	()	Hip Pain	()	()	Bladder Infection	()	()	Depression	()	()
()	()	Knee Pain	()	()	Painful Urination	()	()	Anxiety	()	()
()	()	Ankle Pain	()	()	Loss of Bladder Control	()	()	Frequent Illness	()	()
()	()	Foot Pain	()	()	Prostate Problems	()	()	Epilepsy	()	()
()	()	Jaw Pain/TMJ	()	()	Reflux/Heartburn	()	()	Dermatitis	()	()
()	()	Joint Swelling/Stiffness	()	()	Abnormal Weight Gain	()	()	Eczema	()	()
()	()	Arthritis	()	()	Abnormal Weight Loss	()	()	Poison Ivy/Oak	()	()
()	()	Rheumatoid Arthritis	()	()	Loss of Appetite	()	()	HIV/AIDS	()	()
()	()	General Fatigue	()	()	Constipation	Females Only				
()	()	Ringing in Ears	()	()	Abdominal Pain	()	()	Hot Flashes	()	()
()	()	Visual Disturbances	()	()	Ulcer	()	()	Hormone Replacement	()	()
()	()	Dizziness	()	()	Hepatitis	()	()	Birth Control Pills	()	()
()	()	Nausea	()	()	Liver Disorder	()	()	Painful Periods/Cramps	()	()
			()	()	Gall Bladder Disorder			YES	NO	Are You Pregnant?
			()	()	Cancer			Estimated Due Date _____		
			()	()	Tumor					
			()	()	Asthma					
			()	()	Chronic Sinusitis					
			()	()	Seasonal Allergies					

18. Primary Care Physician _____ 18b. Date of Last Medical Physical _____

19. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: _____

20. List all prescription and over-the-counter medications, nutritional/herbal supplements you are taking:

21. List all the surgical procedures you have had and times you have been hospitalized:

22. Detail ANY history of trauma to head, neck, or back (automobile accidents, sports injuries, work-related accidents, etc):

Patient Signature _____ Date _____