PATIENT INTRODUCTION FORM

Patient Name:	**Today's Date:**
Address:	Home Telephone:
City/State/Zip:	Cell Phone:
Date Birth: Age:	Work Telephone:
Height: Weight:	Email:
Social Security No:	Job Title:
Driver's License No:	

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

_____

IS THIS VISIT RELATED TO A:

☐ Work Related Injury	☐ Motorcycle-Bicycle Injury	☐ Home Injury
☐ Sports or Recreational Injury	☐ Non-Injury Symptoms	☐ Check-up Only
☐ Car Crash Injury	☐ School/Employment Physical	☐ Other (Describe):

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent)_____ Date _____

PAST AND PRESENT GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or currently have:

YES	GENERAL QUESTIONS	YEAR
☐	I bruise easily currently	N/A
☐	I heal slowly currently	N/A
☐	My body temperature is normally low (feel cold) recently	N/A
☐	Smoke cigarettes currently or in the past	N/A
☐	Diabetic	
☐	Heart Attack history (recent and old)	
☐	Epilepsy-Seizure history	
☐	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	
☐	Cancer history or treatment of any type	
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	
☐	Scoliosis	
☐	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	
☐	Rheumatoid arthritis	
☐	Thyroid disorders	
☐	Coma from head injury or other problem	
☐	Told you have osteoporosis of your spine	
☐	Told you have osteoarthritis of your spine or hip joints	
☐	**Women only**: Check this box if you currently have any type of breast implants	N/A
☐	**Women only**: Check this box if there any chance that you are currently pregnant	N/A

PRIOR INJURY HISTORY

(☐ I have no history of previous painful injury) If you have had prior injuries, please check below:

☐ Work Injury ☐ Fall ☐ Sports Injury ☐ Lifting Injury ☐ Car accident
☐ Motorcycle Injury ☐ Bicycle Injury ☐ Pedestrian Injury ☐ Military Injury ☐ Other Injury

FRACTURES/BROKEN BONES

(☐ I have never had any broken bones). If you have broken any bones, indicate where and when:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis bone		☐ Other	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck or back)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Leg		☐ Other	

PAST AND PRESENT GENERAL HEALTH HISTORY (Page 2)

CHECK RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

WHAT SYMPTOM PRIMARILY BOTHERS YOU? _____

SYMPTOM/PAIN DESCRIPTION

Please circle any word or words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious
Ache	Pricking	Shooting	Sickening
Cutting	Tingling	Stabbing	Miserable
Tearing	Gnawing	Dull	Troublesome
Crushing	Nagging	Bony	Pressing
Pulling	Boring	Terrifying	Deep pain
Irritating	Burning-Hot	Dreadful	Superficial pain
Annoying	Drill like	Fearful	Stinging
Stiff or tight	Heavy	Unhappy	Throbbing
Exhausting	Numbness	Torturing	Sharp
Unbearable	Radiating	Suffocating	Tender
Soreness	Weakness	Punishing	Small area
Pins and Needles	Falls asleep	Crawling	Large area

Have you ever been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractors Name : _____ Year:_____

Problem seen for: _____

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Aspirin	☐ Anacin
☐ Anti-inflammatory	☐ Tylenol	☐ Bufferin
☐ Narcotics for Pain	☐ Advil/Motrin	☐ Stroke prevention meds
☐ Heart medications	☐ Birth control medications	☐ Other

WHEN IS YOUR PAIN USUALLY BETTER?

☐ Morning	☐ Afternoon	☐ Evening
☐ During sleep hours	☐ Lying down flat	☐ Standing
☐ Walking	☐ Sitting	☐ Rest
☐ Stress (mental) is less	☐ Good posture	☐ Exercise/Stretching

HAS YOUR PAIN BEEN ASSOCIATED WITH:

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems