Confidential Patient Information

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Would you like to receive information via email? Y N

Date of Birth_____ Sex M F SS#_____ Marital Status M S W D

Spouses Name _____ # of Children_____

Emergency Contact _____Phone_____

Insurance Name_____ Id#_____ Phone_____

Subscriber or Insured Name_____ Subscriber Date of Birth_____

Parent or Legal Guardian if under 18_____

Address if different than above_____

Employer_____ Phone_____

Address_____

Job Title_____

How did you hear about our office?_____

Current Condition

Present Complaints_____

_____

On a scale of 1-10, please rate the severity of your symptoms (10 is most severe) _____

When did this condition begin?_____

Have you had or been treated for same or similar condition before? Yes No

Describe_____

Have you ever seen a chiropractor before? Yes No Who?_____

Have you seen another doctor about your present symptoms? Yes No

Name_____ Treatment_____

Have you been hospitalized for this condition? Yes No When_____

Hospital_____

List medications you are taking_____

List supplements you are taking_____

_____

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Confidential Patient Information Continued

Is your condition the result of an accident/injury? Yes No Date_____
Describe_____
Were you hurt on the job? Yes No Describe_____
_____
Are you covered by Worker's Compensation? Yes No
Do you have a claim open? Yes No Where?_____ Claim #_____
Are you unable to work due to present condition? Yes No Since_____
Are you experiencing other restrictions due to present condition? Yes No
Describe_____

Health History

Have you had any major surgeries? Yes No Please indicate date(s) and procedures:
_____
Have you had any prior injuries or accidents? Yes No Please give date(s) and descriptions:
_____
Please indicate any other health problems below. Circle **C** for current, **P** for past and **F** for family.

Heart or Circulatory Problems	C P F	_____
Digestive or Bowel Problems	C P F	_____
Respiratory Problems	C P F	_____
Eye, Ear, Nose Throat Problems	C P F	_____
Tooth or Jaw Problems	C P F	_____
Skin Problems	C P F	_____
Allergies	C P F	_____
Numbness or Tingling	C P F	_____
Confusion or Depression	C P F	_____
Kidney or Urinary Problems	C P F	_____
Recurrent Infections/Fevers	C P F	_____
Arm or Leg Pain	C P F	_____
Back or Neck Pain	C P F	_____
Menstrual Problems	C P F	_____
Prostate Problems	C P F	_____
Cancer	C P F	_____

Comments_____

Nutritional Survey

Name_____ **Date**_____

Point Scale

0 Never
1 Rarely (1-6x/yr)
2 Occasionally (6-12x/yr)
3 Frequently (once per week or more)
4 Constantly

Section One

___ Bloated after eating
___ Gas shortly after eating
___ Burning stomach relieved by eating
___ Indigestion shortly after eating
___ Coated tongue
___ Indigestion relieved by antacids, milk or carbonated beverages
___ TOTAL

Section Two

___ Burning or itching feet
___ Recurring skin rashes
___ Fats and greasy food upset digestion
___ Pain between shoulder blades
___ Constipation or diarrhea
___ Light colored stools
___ Nightmares, bad dreams
___ TOTAL

Section Three

___ Crave sweets or coffee in afternoon
___ Feel shaky or irritable if meals are missed or delayed
___ Feel hungry between meals
___ Fatigue relieved by eating
___ Awaken after a few hours of sleep, difficult to get back to sleep
___ Confusion, poor memory, faintness, Dizziness
___ TOTAL

Section Four

___ Frequent colds/flu
___ Allergies
___ Red, itchy eyes
___ Wounds heal slowly
___ Gums bleed easily
___ Sinus congestion, post nasal drip
___ Excessive hair loss
___ TOTAL

Section Five

___ Chronic Fatigue
___ Weakness, dizziness
___ Increased perspiration
___ Crave salt
___ Arthritic symptoms
___ TOTAL

Section Six

___ Joint pain
___ Depression/mood swings
___ Reduced sex drive
___ Night sweats
___ Fatigue easily
___ Weight gain
___ Women: menstrual symptoms
___ Men: prostate problems, difficult or frequent urination, esp. at night
___ TOTAL

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Nutritional Questionnaire

Name: _____ **Date:** _____

To help me better understand how your eating practices may be affecting your health, I would appreciate you taking a few minutes to complete this questionnaire. Please check off your answer to each question as accurately as you can. Thank you.

Questions	***Never***	***Occasionally***	***Regularly***
Do you eat breakfast?			
Do you eat lunch?			
Do you eat dinner?			
Do you follow a food combining program?			
Do you eat red meat?			
Do you eat white meat & fish?			
Does your daily diet include fruit?			
Does your daily diet include vegetables?			
Do you drink soft drinks?			
Do you drink diet soft drinks?			
Do you use artificial sweeteners?			
Do you drink coffee or tea?			
Do you drink tap water?			
Do you take prescription drugs?			
Do you take over-the-counter medicines?			
Do you take antacids?			
Do you have sugar cravings?			
Do you read labels for fat content?			
Do you eat foods with MSG?			
Do you take vitamin supplements?			
Do you eat deep fried foods?			
Do you eat chocolate?			
Do you consume dairy products inc. ice cream?			
Do you snack on “junk foods”?			
Do you drink alcoholic beverages?			
Do you smoke or chew tobacco?			
Are you exposed to second hand smoke?			
Do you eat out in restaurants?			
Do you have allergic reactions to foods?			
Would you like to weigh less?			
Would you like to weigh more?			
Do you snack between meals?			
Do you experience intestinal gas after eating?			
Do you experience any digestive discomfort?			

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Stress Questionnaire

Name:_____ **Date:**_____

To help me understand how your stress level may be affecting your health, I would appreciate you taking just a few minutes to complete this questionnaire. Please check off your answer to each question as accurately as you can as it applies to your life within the last 12 months. Thank you.

Questions	***No***	***Yes***
Do you regularly perform aerobic exercise?		
Do you feel stress is a big factor in your life?		
Are you regularly exposed to airborne pollutants or toxins?		
Do you use a computer?		
Do you microwave your food?		
Do you live or work near high voltage power lines?		
Has a family member or friend died in the last year?		
Have you married, separated or divorced in the last year?		
Are you or a family member experiencing any health problems?		
Do you have ongoing relationship challenges?		
Are you experiencing financial pressures?		
Have you or a family member lost a job recently?		
Have you moved to a new home or position at work?		
Do you have boss or work challenges?		
Are you retired or contemplating retirement?		
Have you or a family member started a new job recently?		
Have your sleep patterns changed?		
Have your eating habits changed?		
Are you starting or ending a school year?		
Have you recently purchased or sold your home?		
Have you assumed more or less responsibilities at work?		
Has your social life changed significantly?		
Are you experiencing any legal problems?		
Are you expecting or have a new baby in the family?		
Have any older children left home?		
Are vacations and holidays happy times?		
Have your recreation patterns changed?		
Can you relax after work?		
Is substance abuse a factor in your or a family member's life?		

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