PATIENT INITIAL HEALTH STATUS

PATIENT INFORMATION

Name:________________________ **Birthdate:**______________ **Sex:** M / F

Home address:________________________ City______________ State_____ Zip ______

Phone: (____)__________ **E-mail:** ____________________ **Work Phone:** (____)__________

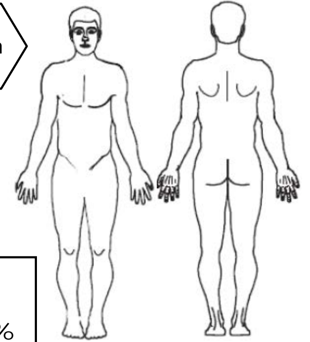
Occupation:____________________ **Employer:**________________________

Emergency contact person: ____________________ **Relationship:**______________

Emergency phone: (____)__________ **Referred by** (How did you find us?)______________

CURRENT CONDITION

Please mark an X on the picture where you have pain or other symptoms.



◆ **Your current problem**

☐ Headache ☐ Neck Pain ☐ Mid Back Pain

☐ Low Back Pain ☐ Other____________________

◆ **Is this?** ☐ Work Related ☐ Auto Related ☐ N/A

◆ **Date Problem Began:**______________ ◆ **How Problem Began:**______________

Current Complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Unbearable Pain)

How often are your symptoms present?

☐ 0-25% (Occasional) ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

0 1 2 3 4 5 6 7 8 9 10

(No interference) (Unable to carry on any activities)

◆ **Have you had spinal X-ray, MRI, CT Scan for your area(s) of complaint?**

☐ No

☐ Yes Date taken:______________

What areas were taken?

____

◆ **In general would you say your overall health right now is:**

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

MEDICAL RECORD

◆ **Please check all the following that apply to you:**

☐ Recent Fever
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks______
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Cancer/ Tumor (explain) ____________________
☐ Osteoporosis
☐ Alcohol/Drug Dependence
☐ Other Health Problems (explain) ____________________
☐ Surgeries ____________________
☐ Prostate Problems
☐ High Blood Pressure
☐ Lungs Disease
☐ Corticosteroid Use (Cortisone, prednisone, etc)______________
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Epilepsy/Seizures
☐ Numbness in Groin/Buttocks
☐ Diabetes
☐ Heart Disease
☐ Stroke (date)______________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Visual Disturbances
☐ Pain at Night
☐ Medication______________
☐ Tobacco Use-Type
Frequency ______________/Day

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit though this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature________________________ **Date**______________