Atlantic Chiro Care

PATIENT HISTORY

Date of Birth _____ Age _____ Social Security # _____

Last _____ First _____ Middle Initial _____

Address _____ City _____ ST_____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Your Occupation _____ Employer _____

Spouse's Name _____ Spouse DOB _____ Spouse SSN: _____

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____

Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you smoke? ☐yes ☐no If yes, how many packs per week? _____

Have you ever smoked in the past? ☐yes ☐no If yes, when did you quit? _____

Do you take birth control? ☐yes ☐no Have you ever taken birth control in the past? ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons: _____

_____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

_____

_____

PATIENT SIGNATURE _____ DATE _____

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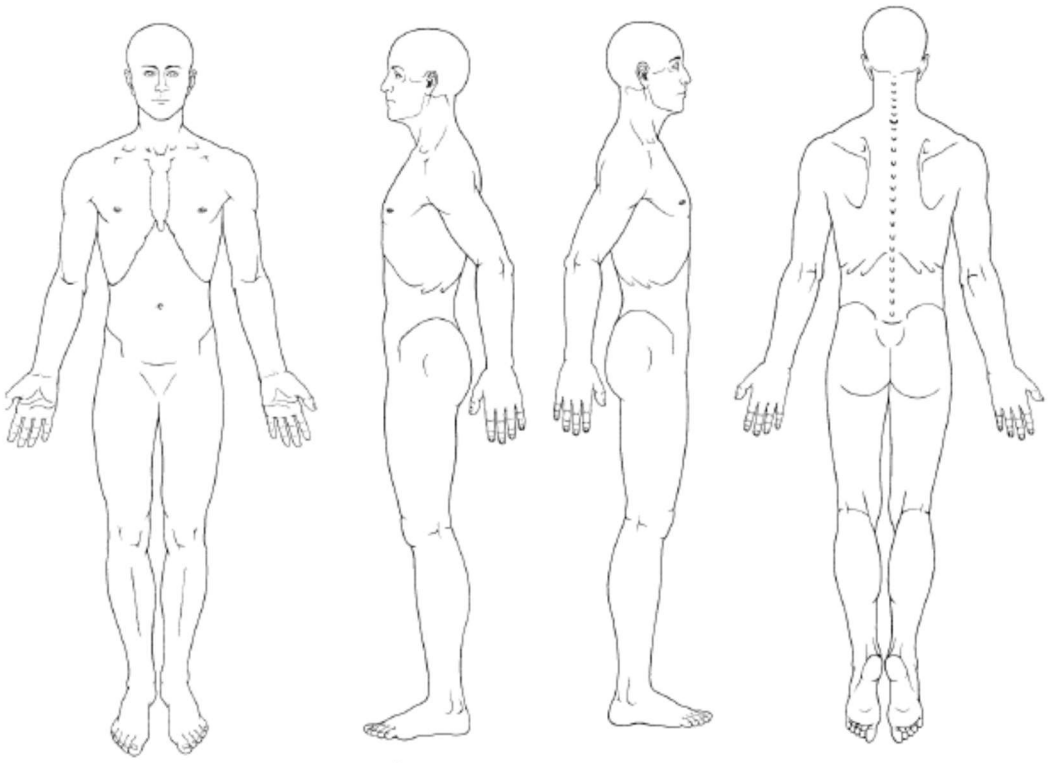
Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Please list all surgeries, injuries, accidents, falls, etc: _____

_____

_____

_____

_____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
☐ Other:				

PATIENT SIGNATURE _____ DATE _____