PATIENT INFORMATION **(OFFICE USE) Ins Code______Patient ID__________DR.________**

Please give your Driver's license and insurance card to the front desk so they can make a copy for your records.
Patient Name: Last ______________________ First _________________________ Date ______/______/______
Address _______________________________ City ___________________ State_______ Zip_______________
Phone (____) ____- ______ Driver's License # ______________________Birthdate_____/_____/_____ Age____
Sex: ___M___F Patient Soc. Sec. # ________-________-_________ Marital Status S M D W Children # ____
Spouse's Name ______________________ Person responsible for payment ______________________________
Patient employed by _____________________________ Occupation ____________________________________
Work phone (____) _______-________ Referred by ______________________ E-mail ______________________
Have you ever been to Chiropractor before yes no Have you ever had similar complaint? yes no
Condition related to: Employment Auto accident personal injury

CURRENT COMPLAINTS

Complaint 1__________________

How severe is the problem?
- ☐ Mild
- ☐ Mild to moderate
- ☐ Moderate
- ☐ Moderately severe
- ☐ Severe

How frequently does it occur?
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

When was the onset?
- ☐ A day ago
- ☐ Several days ago
- ☐ About a week ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ About a year ago
- ☐ several years ago

Movement:
- ☐ Cramps
- ☐ Spasm
- ☐ Stiffness
- ☐ Restricted movement
- ☐ Inflexibility

What makes it feel better?______

What makes it feel worse?_______

If you are being re-evaluated, what percent improvement have you had?
_______%

Complaint 2__________________

How severe is the problem?
- ☐ Mild
- ☐ Mild to moderate
- ☐ Moderate
- ☐ Moderately severe
- ☐ Severe

How frequently does it occur?
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

When was the onset?
- ☐ A day ago
- ☐ Several days ago
- ☐ About a week ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ About a year ago
- ☐ several years ago

Movement:
- ☐ Cramps
- ☐ Spasm
- ☐ Stiffness
- ☐ Restricted movement
- ☐ Inflexibility

What makes it feel better?______

What makes it feel worse?_______

If you are being re-evaluated, what percent improvement have you had?
_______%

Complaint 3__________________

How severe is the problem?
- ☐ Mild
- ☐ Mild to moderate
- ☐ Moderate
- ☐ Moderately severe
- ☐ Severe

How frequently does it occur?
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

When was the onset?
- ☐ A day ago
- ☐ Several days ago
- ☐ About a week ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ About a year ago
- ☐ several years ago

Movement:
- ☐ Cramps
- ☐ Spasm
- ☐ Stiffness
- ☐ Restricted movement
- ☐ Inflexibility

What makes it feel better?______

What makes it feel worse?_______

If you are being re-evaluated, what percent improvement have you had?
_______%