FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

PCP REVAL:

PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****
Patient Name: Last _____ First _____ Date _____ / _____ / _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____
Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____
Marital Status: S M D W Spouse's Name: _____ Referred by: _____
Person responsible for payment: _____ Patient Employed by: _____
Occupation: _____ Work Phone: (____) ____ - _____
Email: _____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email
Have you ever been to a Chiropractor before?: YES NO
Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation

CAUSATION:

The cause for your visit today was from (Select one):

- □ Unknown factors
- □ auto accident
- □ work injury
- □ other accident
- □ trauma
- □ illness
- □ aggravation of a congenital problem

Date of onset (if known): ____ /____ / ____

OR (Select one):

- □ few days ago
- □ week ago
- □ couple of weeks ago
- □ month ago
- □ several months ago
- □ more than a year ago

Have you ever had this complaint before this onset? (circle one): Y N
If you circled yes, select the number of times:

- □ one
- □ two
- □ three
- □ four
- □ more than four times
- □ multiple times

Since the onset of this complaint, it has been (circle one):

- □ improving
- □ getting worse
- □ staying the same
- □ intermittent

Please add any other information about the primary complaint that may be helpful:

_____

PATIENT'S INITIALS_____DATE_____

CHIEF COMPLAINT:

Please select the answers that best describe your primary complaint for today's visit. Choose MORE than one answer if appropriate.

WHERE is your WORST pain?

- □ back of the head
- □ forehead
- □ area behind the eye
- □ face
- □ neck
- □ shoulder
- □ arm
- □ hand
- □ fingers
- □ upper back
- □ chest
- □ low back and buttock region
- □ abdomen
- □ groin
- □ "tailbone"
- □ hip
- □ knee
- □ leg
- □ foot

What word(s) BEST describe(s) you pain?

- □ constant
- □ intermittent
- □ mostly on the right side
- □ mostly on the left side
- □ about equal on both sides
- □ radiating from the neck into the back of the head
- □ radiating from the neck into the shoulder
- □ radiating from the neck into the arm and hand
- □ radiating into the chest
- □ radiating into the abdomen
- □ radiating into the groin
- □ radiating into the buttock and thigh
- □ radiating into the entire leg and foot
- □ "shooting"
- □ "burning"
- □ "stinging"
- □ "crawling"
- □ "aching"
- □ "throbbing"

PATIENT'S INITIALS_____DATE_____

REVIEW OF SYSTEMS:

If you have an issue in a section below, select your issue from the list. If you have no problems for a particular question, select the "No symptoms" box.

Do you have any ill feelings?
- □ No symptoms
- □ Decreased activity level
- □ Fever
- □ Chills
- □ Fatigue
- □ Night sweats
- □ Loss of appetite
- □ Weight loss
- □ Weight gain
- □ Loss of energy
- □ Uncontrolled sweating

Do you have any mental health problems?
- □ No symptoms
- □ Irritability
- □ Depression
- □ Disturbed sleep
- □ Suicidal thoughts
- □ Anxiety
- □ Nervousness

Do you have any trouble urinating?
- □ No symptoms
- □ Frequent urination
- □ Urgency
- □ Trouble stopping or starting stream
- □ Erectile dysfunction
- □ Nocturia
- □ Burning with urination
- □ Losing control/incontinence
- □ Bowel dysfunction
- □ Sexual dysfunction
- □ Hesitancy

Do you have trouble with your vision?
- □ No symptoms
- □ Blurred vision
- □ Double vision
- □ Vision loss
- □ Work glasses/contacts

Do you have any symptoms of heart trouble?
- □ No symptoms
- □ Chest pain
- □ Palpitations
- □ Fainting
- □ Shortness of breath
- □ Ankle swelling

Do you have any breathing problems?
- □ No symptoms
- □ Coughing
- □ Wheezing
- □ Shortness of breath

Do you have stomach problems?
- □ No symptoms
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Loss of bowel control

Do you have muscle or joint problems?
- □ No symptoms
- □ Joint pain
- □ Joint weakness
- □ Muscle weakness

Do you have any skin problems?
- □ No symptoms
- □ Rash
- □ Itching
- □ Dryness
- □ Lesions
- □ Open wounds/infection
- □ Hair/nail changes

Do you have any immunity problems?
- □ No symptoms
- □ Enlarged lymph nodes
- □ Hives
- □ Hay fever
- □ Persistent infections

Do you have any endocrine problems?
- □ No symptoms
- □ Diabetes
- □ Thyroid disorder

Do you have any neurological problems?
- □ No symptoms
- □ Seizures
- □ Abnormal sensory feelings in extremity
- □ Loss of memory

Do you have any bruising or bleeding problems?
- □ No symptoms
- □ History of anemia
- □ Abnormal bleeding
- □ Bruising
- □ Heat intolerance
- □ Cold intolerance

PATIENT'S INITIALS_____DATE_____

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:

ALLERGIES:

Please list any allergies as well as your reaction to the allergen if known.

Environmental Allergies: _____

Food Allergies: _____

Medication/Drug Allergies: _____

PATIENT'S INITIALS_____DATE_____