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

PRIMARY CARE FOLLOW-UP:
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

CHIEF COMPLAINT: **Answer the questions as completely as possible. If a question does not apply, leave it blank.**

Reason for today's appointment (Annual physical, Lab work, Sick visit, etc): _____

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Occasionally (26-49%) ☐ Intermittently (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

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

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

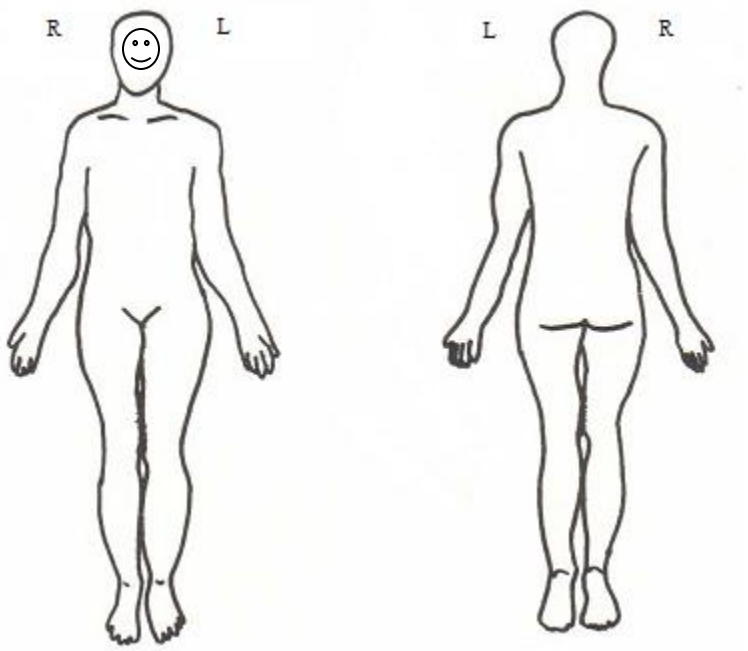
PATIENT'S INITIALS_____DATE_____

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

KEY:	
Numbness / Tingling	**=======**
Pins & Needles	**oooooooo**
Burning pain	**xxxxxxxx**
Dull / achy pain	**……**
Sharp / Stabbing pain	**////////////////**



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain ——— **Worst pain**

0 (1) 2 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE ☐

ALLERGIC/IMMUNOLOGIC: ☐ **NONE** Food Allergies/sensitivities Seasonal allergies/Hay fever Hives

CARDIOVASCULAR: ☐ **NONE** Ankle swelling Blood clots Chest pain Feeling light headed with standing Heart murmur Heart problems High blood pressure High cholesterol Leg pain with walking short distances Low blood pressure Palpitations (heart skipping beats) Poor circulation Rapid heartbeat Sores that don't heal Varicose veins

CONSTITUTIONAL: ☐ **NONE** Chills Difficulty concentrating Difficulty sleeping Fatigue Fainting Fever Low libido Nervousness Night Sweats Poor appetite Weakness

EARS, NOSE &THROAT: ☐ **NONE** Blisters/cold sores Chronic ear infection Dental problems/toothaches Deviated septum Dry mouth Dysphagia/trouble swallowing Ear noises/ringing Ear pain Gum disease Hearing loss Loss of smell Loss of taste Loss of teeth/ have dentures Motion sickness Nose bleeds Nasal breathing problems Nasal drip Nasal polyps Recurrent ear infections Sinus infections/pain Sore throat/hoarseness Sores/ulcers Tonsillitis Vertigo/dizziness

ENDOCRINE: ☐ **NONE** A loss of appetite Being unusually jumpy or nervous Changes in hair growth or distribution Cold intolerance Excessive hunger Excessive thirst Feeling drowsy after eating Feeling shaky or faint when hungry Heat intolerance Hyperthyroid Hypothyroid Type I diabetes Type II diabetes Unexplained weight gain Unexplained weight loss

EYES: ☐ **NONE** Burning in the eyes Blurred vision Cataracts Dry or gritty eyes Far sightedness Glaucoma Itchy eyes Near sightedness Redness Swelling Tearing/crusting Vision headaches

GASTROINTESTINAL: ☐ **NONE** Abdominal gas Abdominal pain Acid reflux/heart burn Anorexia/Bulimia Constipation Diarrhea Discolored stool Frequent indigestion Gall bladder disease Hemorrhoids Liver disease Nausea Stomach Ulcers Vomiting

GENITOURINARY: ☐ **NONE** A discharge other than urine Bedwetting Bladder control problems Cloudy/foul smelling urine Difficulty starting a stream Discolored urine Dribbling Endometriosis Erectile dysfunction Frequent urination Getting up at night to urinate Infertility Kidney stones Kidney or bladder infections Painful urination PMS symptoms Urgency Uterine cysts Uterine fibroids

HEMATOLOGIC/LYMPHATIC: ☐ **NONE** Anemia Bleeding or bruising Blood clots Hemophilia Hepatitis A Hepatitis B Hepatitis C HIV/AIDS Jaundice Liver problems Lymphoma Myeloma Swollen Glands

INTEGUMENTARY/SKIN: ☐ **NONE** Acne Bruising Dandruff Dryness Eczema Excessive Sweating Nail fungus Plantar warts Psoriasis Rashes Skin cancer Sores

MUSCULOSKELETAL: ☐ **NONE** Arthritis Back pain/injuries General muscle tension Heel spurs Joint pain Joint stiffness Joint swelling Leg/foot cramps during the day Leg/foot cramps when retiring to bed or at night Muscle cramps Muscle pain Muscle Weakness Neck pain/ injuries Pain between the shoulders Painful feet Rheumatoid arthritis Scoliosis TMJ pain

NEUROLOGICAL: ☐ **NONE** Confusion Convulsions Difficulty of speech Double vision Epilepsy Fainting spells Headaches Incoordination Losing consciousness Loss of feeling Memory loss Meningitis Muscle jerking/twitching/tics Numbness/tingling Paralysis Pins/needles Seizures Stuttering

PSYCHIATRIC: ☐ **NONE** Alcoholism Anxiety Considerable emotional stress Crying often Depression Drug addictions/dependency Eating when nervous Extreme worry Feeling angered or irritable Hallucinations Insecurity Nail biting Phobias Recurrent bad dreams Sleep walking Suicidal thoughts

RESPIRATORY: ☐ **NONE** Apnea Asthma Congestion COPD Coughing up blood Difficulty breathing Emphysema Non-productive/dry cough Pneumonia Productive cough Shortness of breath Wheezing

SURGICAL HISTORY:

Please list any surgeries that you have had your LAST evaluation. Also INCLUDE RIGHT OR LEFT side of body where applicable.

- □ **I have NOT had any NEW surgeries since my LAST evaluation.**

PROCEDURE:	DATE:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Enviromental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

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

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