Brielle
Integrated Healthcare

Patient Introduction

| General Information |

Today's Date _____

Patient name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Patient Sex: *M F*   Marital Status: *S M W D*   Number of Children _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Patient E-Mail Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Emergency Contact: Name: _____ Phone: _____

Have you ever seen a chiropractor before? YES/NO

    If you answered YES, when was your last visit? _____

Have you ever had an acupuncture treatment? YES/NO

    If you answered YES, when was your last visit? _____

How did you find out about our office? _____

Are you or have you ever been a member of Brielle Sports Club (GYM)?

YES or NO

PLEASE TURN OVER

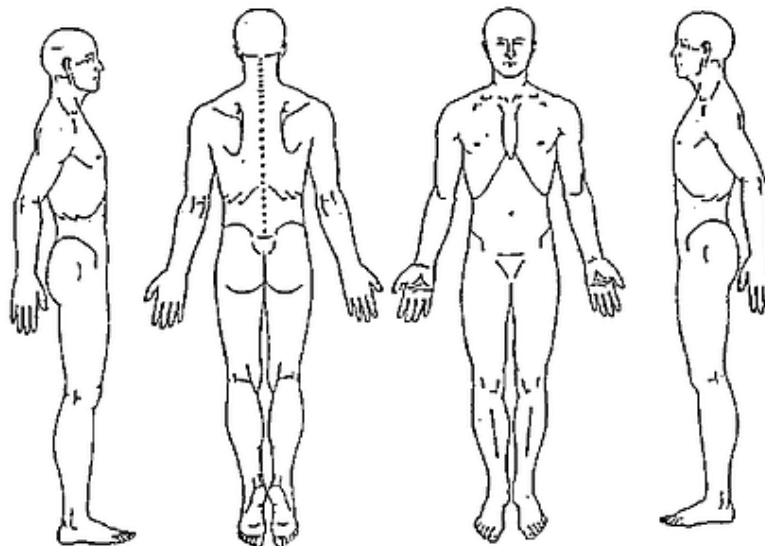## Health History

Describe your current complaint: _____

Have you ever had prior treatment for this issue?_____

How did it begin? _____

How long have you had it?_____

Please rate your pain level: 0 1 2 3 4 5 6 7 8 9 10
                              (no pain)   (moderate pain)   (terrible pain)

Please shade the areas where you feel pain.

Below is a listing of symptoms, conditions or habits.   Please check all that apply:

Symptoms	Past	Present	Symptom	Past	Present		Past	Present
Neck pain	[ ]	[ ]	High blood pressure	[ ]	[ ]	Tobacco use	[ ]	[ ]
Shoulder pain	[ ]	[ ]	Heart condition	[ ]	[ ]	Alcohol use	[ ]	[ ]
Arm/elbow pain	[ ]	[ ]	Respiratory condition	[ ]	[ ]	Caffeine use	[ ]	[ ]
Hand pain	[ ]	[ ]	Digestive problems	[ ]	[ ]	Pregnancy	[ ]	[ ]
Upper back pain	[ ]	[ ]	Kidney/bladder problem	[ ]	[ ]	Surgery	[ ]	[ ]
Lower back pain	[ ]	[ ]	Menstrual problems	[ ]	[ ]	Please List _____		
Pain in upper leg or hip	[ ]	[ ]	Breast soreness/lumps	[ ]	[ ]	_____		
Pain in lower leg or knee	[ ]	[ ]	Sinus condition	[ ]	[ ]	_____		
Pain in ankle or foot	[ ]	[ ]	Allergies/asthma	[ ]	[ ]	_____		
Jaw pain	[ ]	[ ]	Cancer	[ ]	[ ]	_____		
Swelling/stiffness of joints	[ ]	[ ]	Stroke	[ ]	[ ]	_____		
Headaches	[ ]	[ ]	Excessive weight loss/gain	[ ]	[ ]	_____		
Dizziness	[ ]	[ ]	Skin condition	[ ]	[ ]	_____		
Fainting spells	[ ]	[ ]	Arthritis	[ ]	[ ]	_____		
Convulsions	[ ]	[ ]	Diabetes	[ ]	[ ]	_____		
General prolonged fatigue	[ ]	[ ]	Prostate condition	[ ]	[ ]	_____		
Condition of uterus/ovaries	[ ]	[ ]						