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: __________________

Primary Doctor Name:_____________________ Phone:____________ Last Seen:_________

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?___________________________________

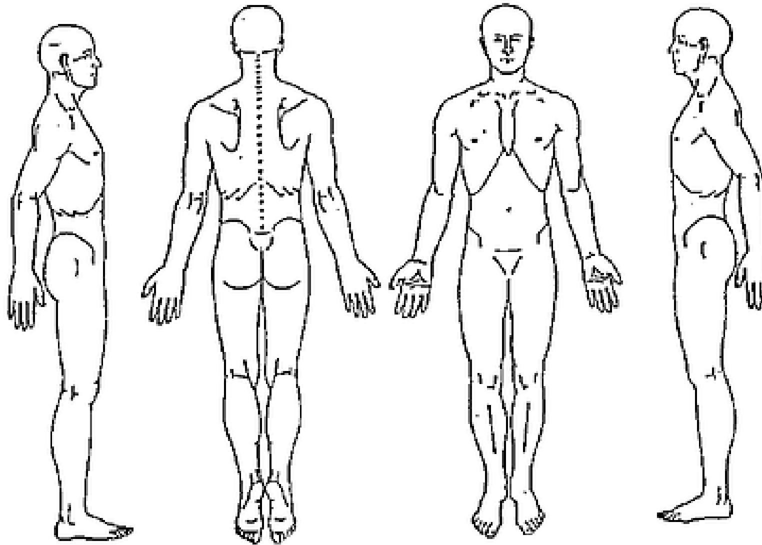
How did it begin? ____

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	[ ]	[ ]						