



### Confidential Patient Information

Name: \_\_\_\_\_ Prefer To Be Named: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: M S W D

Check here to receive our Email newsletter and updates. My Email is: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Name of Husband or Wife: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

### Current Health History

Area of Complaint/s: \_\_\_\_\_

Date Problem Began: \_\_\_\_\_ How did your problem begin? \_\_\_\_\_

How would you describe the pain?  Sharp  Dull  Diffuse  Achy  Burning  Shooting  Stiff  Numb  
 Tingly  Sharp w/motion  Shooting w/motion  Stabbing with motion  Electric like w/motion

Does the pain radiate?  Localized to spine  Radiates below elbow or knee  Radiates to face  Other

Using a scale from 0-10 (10 being the worst), how would you rate your problem? 1 2 3 4 5 6 7 8 9 10

The problem is:  Getting Worse  Staying the same  Getting Better

How often do you experience your condition?

Constantly (76-100%)  Frequently (51-75%)  Occasionally (26-50%)  Intermittently (1-25%)

How much has the problem interfered with your normal daily activities?

Not at all  A little bit  Moderately  Quite a bit  Extremely

How much has the problem interfered with your work/required tasks?

Not at all  A little bit  Moderately  Quite a bit  Extremely  Do not work

Have you had anything like this before?  Yes  No How many times?  0-3  4-5  > 5

Do you have a history of spinal surgery?  Yes  No Does this area still bother?  Never  < 2/year  > 2/year

Do you consider your problem to be severe?  Yes  Yes, at times  No

What aggravates your problem? \_\_\_\_\_

What makes your problem feel better? \_\_\_\_\_

What concerns you the most about your problem; what does it prevent you from doing? \_\_\_\_\_

Who else have you seen for your problem?  Chiropractor  Neurologist  Primary Care Physician  No one  ER physician  Orthopedist  Massage Therapist  Physical Therapist  Other: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ Medical Group: \_\_\_\_\_

Family Health History  Cancer  Heart Disease  Diabetes  Neurological  Other

How would you rate your overall health?  Excellent  Very Good  Good  Fair  Poor

What type of exercise do you do?  Strenuous  Moderate  Light  None

Past Present		Past Present		Past Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
			<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
			<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
			<input type="checkbox"/>	<input type="checkbox"/>	Stroke
			<input type="checkbox"/>	<input type="checkbox"/>	Angina
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder
			<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
			<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
			<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
			<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
			<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Change
			<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
			<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
			<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
			<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
			<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder
			<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
			<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
			<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances

**For Females Only**  
 Birth Control Pills  
 Hormonal Replacement  
 Pregnancy

List all the prescription medications you are currently taking: \_\_\_\_\_

List all the vitamins/supplements you are currently taking: \_\_\_\_\_

List all the surgical procedures you've had: \_\_\_\_\_

What activities do you do at work?

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Sit           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

What activities do you do outside of work? \_\_\_\_\_

Have you had any significant past trauma? \_\_\_\_\_

Anything else we should know? \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Thompson Valley Chiropractic, PC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Thompson Valley Chiropractic, PC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient /Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_