

## Patient Information Form

Today's Date:		Date of Birth:	
Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Age: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other _____
Address:		City:	State: Zip:
Email:		Cell Phone:	Home Phone:
Spouse's Name:		Ages of Children:	Occupation/Job Title:
Employer/Business Name:		Business Address:	Business Phone:
Type of Work:		How Did You Hear About Us?	
Emergency Contact:		Relationship:	Phone #:

### CURRENT HEALTH CONDITION

	Chief Complaint: (why are you here today?)

Please circle areas of discomfort

Body Area Involved:	<input type="checkbox"/> Cervical (neck) <input type="checkbox"/> Upper Extremity (arms, wrist, hands) <input type="checkbox"/> Spine (mid-back), ribs, pelvis (low-back) <input type="checkbox"/> Lower Extremity (legs, feet, toes)
Condition:	<input type="checkbox"/> New <input type="checkbox"/> Recurring <input type="checkbox"/> Exacerbation <input type="checkbox"/> Chronic
Mechanism of Onset:	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Sports Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Slip or Fall <input type="checkbox"/> Other <input type="checkbox"/> Slept Wrong <input type="checkbox"/> No injury <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Over exertion
Symptoms:	<input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness
Location:	<input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Right
Quality:	<input type="checkbox"/> Burning <input type="checkbox"/> Dull/Aching <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Tightness <input type="checkbox"/> Radiating <input type="checkbox"/> Diffuse <input type="checkbox"/> Localized <input type="checkbox"/> Shooting <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Other _____

On a scale of 0-10, (10 being the worst) Rate your symptoms (Resting):	0	1	2	3	4	5	6	7	8	9	10
--	---	---	---	---	---	---	---	---	---	---	----

On a scale of 0-10, (10 being the worst) Rate your symptoms (with Activity):	0	1	2	3	4	5	6	7	8	9	10
Duration: Symptom(s) Started:											
Symptom(s) Worsened:											
Symptom(s) Last Occurred:											
Injury Occurred:											
Accident Occurred:											
Timing Worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Night <input type="checkbox"/> W/Activity <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent											
Associated Signs & Symptoms: <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Headaches <input type="checkbox"/> Nausea <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Vision Problems <input type="checkbox"/> Irritability <input type="checkbox"/> Mood Swings <input type="checkbox"/> Stiffness <input type="checkbox"/> Depression <input type="checkbox"/> Radiating <input type="checkbox"/> Localized Tingling <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Dizziness											
Quality of Headaches: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aura <input type="checkbox"/> Radiation: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> No Aura <input type="checkbox"/> Weakness: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral											
Other Assoc. Signs & Symptoms: <input type="checkbox"/> Aches <input type="checkbox"/> Fever <input type="checkbox"/> Numbness <input type="checkbox"/> Runny Nose <input type="checkbox"/> Tingling <input type="checkbox"/> Cold Limb <input type="checkbox"/> Heartburn <input type="checkbox"/> Pale Bluish Skin <input type="checkbox"/> Stiffness <input type="checkbox"/> Vomiting <input type="checkbox"/> Dizziness <input type="checkbox"/> Muscle Spasm <input type="checkbox"/> Panic <input type="checkbox"/> Sweating <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Nausea <input type="checkbox"/> Pins & Needles <input type="checkbox"/> Swelling											
Modifying Factors – Symptoms Better With: <input type="checkbox"/> Activity <input type="checkbox"/> Cold <input type="checkbox"/> Massage <input type="checkbox"/> OTC Meds <input type="checkbox"/> Rest <input type="checkbox"/> Sitting <input type="checkbox"/> Twisting <input type="checkbox"/> Bending <input type="checkbox"/> Heat <input type="checkbox"/> Movement <input type="checkbox"/> RX Meds <input type="checkbox"/> Stretching <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Nothing Helps											
<b>EMPLOYMENT</b>											
Occupation:						Work (hrs/day):					
Job Classification: <input type="checkbox"/> Sitting <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy Lifting						Lifting Frequency: <input type="checkbox"/> Constant (66-100% day) <input type="checkbox"/> Frequent (33-65% day) <input type="checkbox"/> Occasional (0-32% day)					
Work Activity Postures: (hrs/day) <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Pushing <input type="checkbox"/> Kneeling <input type="checkbox"/> Twisting <input type="checkbox"/> Standing <input type="checkbox"/> Climbing <input type="checkbox"/> Pulling <input type="checkbox"/> Reaching <input type="checkbox"/> Bending											
Repetitive Activities (hrs/day): <input type="checkbox"/> Computer <input type="checkbox"/> Machinery <input type="checkbox"/> Assembly <input type="checkbox"/> Phone <input type="checkbox"/> Hand Tools <input type="checkbox"/> Grasping											
How Does This Condition Effect Job Performance?: <input type="checkbox"/> Mild Painful (Can Do) <input type="checkbox"/> Severe (Unable to Do) <input type="checkbox"/> Moderate Painful (Limited) <input type="checkbox"/> Other (Explain)											

**DAILY ACTIVITIES: ON A SCALE OF 0-10, TO WHAT LEVEL ARE YOU EXPERIENCING SYMPTOMS WHILE PERFORMING THESE ACTIVITIES**

Activity (Check applicable column)	0 No Effect	1	2	3	4	5	6	7	8	9	10 Unable to do
Bending:											
Carrying Things:											
Change Pos. -Sit-Stand:											
Climb Stairs:											
Driving											
Extended Computer Use:											
Eating:											
Exercise:											
Housework:											
Kneeling:											
Lifting:											
Lying Down:											
Reading (Concentration):											
Self Care:											
Sexual Activities:											
Sleep:											
Sitting:											
Sports/Running:											
Standing:											
Stress:											
Stretching:											
Walking:											
Yard Work:											

**BELOW IS A LIST OF DISEASES THAT MAY SEEM UNRELATED TO THE PURPOSE OF YOU'RE APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE. REVIEW OF SYMPTOMS-PLEASE FILL OUT ALL OF THE SECTIONS, EVEN IF DENY**

Constitutional: <input type="checkbox"/> I deny any const. issue(s)	<input type="checkbox"/> Chills <input type="checkbox"/> Night sweats	<input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever	<input type="checkbox"/> Daytime Drowsiness
Eye/Vision: <input type="checkbox"/> I deny any eye/vision issue(s)	<input type="checkbox"/> Blindness <input type="checkbox"/> Double Vision <input type="checkbox"/> Wear glasses and/or contact lenses	<input type="checkbox"/> Eye Pain <input type="checkbox"/> Photophobia	<input type="checkbox"/> Tearing <input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Field Cuts <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Change in vision <input type="checkbox"/> Itching
Ears, Nose, & Throat: <input type="checkbox"/> I deny any E/N/T issue(s)	<input type="checkbox"/> Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Sore throat (frequent) <input type="checkbox"/> Ear infections <input type="checkbox"/> Ear pain	<input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Sinus infections (frequent)	<input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Snoring <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Rhinorrhea (runny nose) <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of smell <input type="checkbox"/> Dental implants <input type="checkbox"/> TMJ Problems
Respiration: <input type="checkbox"/> I deny any respiratory issue(s)	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Sputum production	<input type="checkbox"/> Shortness of breath

Allergy: <input type="checkbox"/> Anaphylaxis (history of sneezing) <input type="checkbox"/> Food intolerance <input type="checkbox"/> Nasal congestion <input type="checkbox"/> I deny any allergy issue(s) <input type="checkbox"/> Itching
Cardiovascular: <input type="checkbox"/> Angina (chest pain/discomfort) <input type="checkbox"/> Claudication (leg pain/achiness) <input type="checkbox"/> Ulcers <input type="checkbox"/> I deny any cardio issue(s) <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart problems <input type="checkbox"/> Swelling of legs <input type="checkbox"/> Varicose veins <input type="checkbox"/> Orthopnea (difficulty breathing while laying down) <input type="checkbox"/> Palpitations (irregular or forceful breathing) <input type="checkbox"/> Paroxysmal (waking up at night with shortness of breath)
Gastrointestinal: <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Indigestion <input type="checkbox"/> Jaundice (yellowing of skin) <input type="checkbox"/> I deny any GI issue(s) <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Belching <input type="checkbox"/> Abnormal stool caliber (quality) <input type="checkbox"/> Abnormal stool color <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Black, tarry stools <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Nausea <input type="checkbox"/> Abnormal stool consistency
Female: <input type="checkbox"/> Birth Control <input type="checkbox"/> Burning urination <input type="checkbox"/> Cramps <input type="checkbox"/> Frequent urination <input type="checkbox"/> I deny any female issue(s) <input type="checkbox"/> Breast lump/pain <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Irregular menstruation <input type="checkbox"/> Urine retention <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Vaginal discharge
Male: <input type="checkbox"/> Burning urination <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Prostrate problems <input type="checkbox"/> I deny any male issue(s) <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urination retention <input type="checkbox"/> Hesitancy/dribbling
Endocrine: <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Excessive hunger <input type="checkbox"/> I deny any endocrine issue(s) <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Goiter <input type="checkbox"/> Hair loss <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Voice changes <input type="checkbox"/> Unusal hair growth
Skin: <input type="checkbox"/> Changes in nail texture <input type="checkbox"/> Changes in skin color <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> I deny any skin issue(s) <input type="checkbox"/> Paresthesia (numbness, prickling, tingling) <input type="checkbox"/> Rash <input type="checkbox"/> Skin lesions/ulcers <input type="checkbox"/> Varicosities <input type="checkbox"/> History of skin disorders
Nervous Systems: <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Numbness <input type="checkbox"/> I deny any NS issue(s) <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Strokes <input type="checkbox"/> Unsteadiness of gait <input type="checkbox"/> Tremors <input type="checkbox"/> Facial weaknes <input type="checkbox"/> Limb weakness <input type="checkbox"/> Loss of memory <input type="checkbox"/> Seizures <input type="checkbox"/> Stress
Psychological: <input type="checkbox"/> Anhedonia (inability to experience or enjoy life) <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> I deny any psych issue(s) <input type="checkbox"/> Anxiety <input type="checkbox"/> Appetite changes <input type="checkbox"/> Behavioural changes <input type="checkbox"/> Confusion <input type="checkbox"/> Convulsions <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Memory loss <input type="checkbox"/> Mood changes
Hematology: <input type="checkbox"/> Anemia <input type="checkbox"/> Blood clotting <input type="checkbox"/> Bruises easily <input type="checkbox"/> Lymph node swelling <input type="checkbox"/> I deny any hematology issue(s) <input type="checkbox"/> Bleeding <input type="checkbox"/> Blood transfusion(s) <input type="checkbox"/> Fatigue
<b>PAST HEALTH HISTORY – PLEASE FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE</b>
Adult Illnesses: <input type="checkbox"/> Alzheimers <input type="checkbox"/> CVA (stroke) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> I deny any adult illness(es) <input type="checkbox"/> Anemia <input type="checkbox"/> Cystic Kidney Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Pleurisy <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Hepatitis <input type="checkbox"/> Psychiatric problems <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes (insulin) <input type="checkbox"/> Hypertension <input type="checkbox"/> Scoliosis <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes (non insulin) <input type="checkbox"/> Influenza/Pneumonia <input type="checkbox"/> Chicken pox <input type="checkbox"/> Ear infections (frequent) <input type="checkbox"/> Liver disease <input type="checkbox"/> HIV <input type="checkbox"/> Chron’s/Colitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Lung disease <input type="checkbox"/> Shingles <input type="checkbox"/> CRPS (RSD) <input type="checkbox"/> Eye problems <input type="checkbox"/> Lupus erythema (discoid) <input type="checkbox"/> Parkinson’s Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Lupus erythema (systemic) <input type="checkbox"/> Vertigo <input type="checkbox"/> Suicide attempt(s) <input type="checkbox"/> STD’s (unspecified) <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Past history of similar symptoms to your current condition
Surgeries: <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Caesarean Section <input type="checkbox"/> Dental surgery <input type="checkbox"/> I deny any surgery(ies) <input type="checkbox"/> Cardiac catheterization <input type="checkbox"/> Carpal tunnel repair <input type="checkbox"/> Coronary artery bypass <input type="checkbox"/> Cosmetic <input type="checkbox"/> D & C <input type="checkbox"/> Gall bladder <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia repair <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Joint reconstruction <input type="checkbox"/> Spinal fusion <input type="checkbox"/> Joint replacement <input type="checkbox"/> Laminectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Rotator cuff <input type="checkbox"/> Pacemaker insertion <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Other: _____

OB/GYN:	<input type="checkbox"/> I have never been pregnant	<b>Menstrual History:</b>	<input type="checkbox"/> My menses is regular
<input type="checkbox"/> I deny OB/GYN issue(s)	<input type="checkbox"/> I have been pregnant in the past	Age of	<input type="checkbox"/> My menses is irregular
	<input type="checkbox"/> I am currently pregnant	onset ____	<input type="checkbox"/> I am currently in menopause
		Date of last menses: ____/____/____	

Injuries:	<input type="checkbox"/> Back injury	<input type="checkbox"/> Fracture	<input type="checkbox"/> Disability	<input type="checkbox"/> Head injury	<input type="checkbox"/> Industrial accident
<input type="checkbox"/> I deny any injury(ies)	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Joint injury	<input type="checkbox"/> Severe laceration	<input type="checkbox"/> Severe soft tissue injury	
	<input type="checkbox"/> Severe fall	<input type="checkbox"/> Motor vehicle accident	<input type="checkbox"/> Mild/Moderate soft tissue injury		

**PLEASE READ CAREFULLY AND SIGN BELOW**

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Precision Chiropractic 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 Precision Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my child's care or treatment, any fees for professional services rendered to me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my child's condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees by this office.

Guardian or spouse's signature of authorizing care: (signature indicates consent to treat)	Date:
Patient (print name):	Patient's Signature:
	Date: