

Name: _____ Nickname: _____

Address: _____ Male Female

City/State/Zip: _____

Birth date: ____/____/____ Age: _____ SS#: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

E-mail address: _____@_____.com

How did you hear about our office? _____

Employer: _____ Occupation _____

Name of Relative not living with you _____ Telephone#: _____

Marital Status: Single Married Spouse's Name: _____

Divorced Widowed

What is your Major Complaint?

Is this condition due to an: Auto Accident Work Related Fall
Other _____

Date of Accident: _____

Which of the following activities aggravate your condition: (Please check all that apply)

- | | | |
|-------------------------------------|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Lying Down | <input type="checkbox"/> Sexual Activity | <input type="checkbox"/> Other _____ |

Are the symptoms: Improving Getting Worse About the Same Intermittent

Have you had similar symptoms in the past? Yes No When? _____

Have you seen another physician for this condition? Yes No Drs. Name: _____

List Surgical Operations: _____

List Current Medications you are taking: _____

I clearly understand that if I am accepted as a patient at Stanfield Chiropractic Inc., I authorize them to proceed with the treatment as necessary. Any risks regarding such treatment will be explained upon request. I also understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. In the case insurance verification is obtained, insurance claims may be filed. I understand that the filing of insurance is not a guarantee of payment, and I remain responsible for the entire amount due. I also understand that if I terminate my care and treatment, any fees for professional services rendered me prior to my termination of care will be immediately due and payable. In the extent of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I hear by attest that the above and all following information is true to the best of my knowledge.

Signature of Patient or Patient's Guardian Date Witness

Who is your primary doctor?

What major surgeries have you had?

What specialists have you seen? Physical therapist, Orthopedic Surgeon, Neurosurgeon, Neurologist, Psychiatrist, Psychologist, Pain Management, Massage, Rheumatologist, Dentist, ENT, Oncologist, Gastroenterologist, Cardiologist?

Give Name, Diagnosis and Treatment:

What other Chiropractor have you seen? _____

Did the treatment help? _____ What type of treatment was received? _____

What supplements/vitamins do you take? _____

What diagnostic tests have you had?

Xrays- date: _____ location _____

MRI date _____ location _____

CT date _____ location _____

Bone Scan date _____ location _____

Bone Density date _____ location _____

Nerve Conduction date _____ location _____

Other _____

Are your symptoms getting? Better Worse Same

Do you have metal in your body? Yes No Where? _____

Do you have a communicable disease? Yes No What disease? _____

Do you have active cancer? Yes No Type? _____

Do you have a history of cancer? Yes No Type? _____

Do you have a Pacemaker? Yes No

Do you have a history of Smoking? Yes No

Do you have a history of oral contraceptives? Yes No

Other health problems? Diabetic, heart problems, liver problems? _____

Are you experiencing any of the following stroke symptoms at this time?

YES NO Sudden difficulty speaking (slurred speech) understanding what people are saying?

YES NO Sudden onset of confusion or altered mental status, such as loss of consciousness, or not recognizing people who should be familiar?

YES NO Sudden numbness or tingling on one side of face or body or both?

YES NO Sudden onset of dizziness or unsteadiness, loss of balance or coordination, or both?

YES NO Sudden difficulty walking or standing upright?

YES NO Sudden severe headache?

YES NO Sudden severe unexplained upper-neck pain?

YES NO sudden trouble with vision or sight?

LIST COMPLAINTS BELOW

1

When did the symptom first appear? _____

Type- Sharp dull aching burning spasm
tightness throbbing tingling numbness _____
Where does it radiate to- _____
What caused this symptom? _____

What percent of time do you experience symptoms?
Constant 76-100% Frequent 51-75% Occasional 26-50% Intermittent 1-25%

How bad is pain?
None 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes pain better? _____

What makes pain worse? _____

Time Worse? - Morning, Noon, Evening, Night

2

When did the symptom first appear? _____

Type- Sharp dull aching burning spasm
tightness throbbing tingling numbness _____
Where does it radiate to- _____
What caused this symptom? _____

What percent of time do you experience symptoms?
Constant 76-100% Frequent 51-75% Occasional 26-50% Intermittent 1-25%

How bad is pain?
None 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes pain better? _____

What makes pain worse? _____

Time Worse? - Morning, Noon, Evening, Night

3

When did the symptom first appear? _____

Type- Sharp dull aching burning spasm
Tightness throbbing tingling numbness _____
Where does it radiate to- _____
What caused this symptom? _____

What percent of time do you experience symptoms?
Constant 76-100% Frequent 51-75% Occasional 26-50% Intermittent 1-25%

How bad is pain?
None 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes pain better? _____

What makes pain worse? _____

Time Worse? - Morning, Noon, Evening, Night

4

When did the symptom first appear? _____

Type- Sharp dull aching burning spasm
tightness throbbing tingling numbness _____
Where does it radiate to- _____
What caused this symptom? _____

What percent of time do you experience symptoms?
Constant 76-100% Frequent 51-75% Occasional 26-50% Intermittent 1-25%

How bad is pain?
None 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes pain better? _____

What makes pain worse? _____

Time Worse? - Morning, Noon, Evening, Night

Patient _____ # _____

Date _____

Review of Systems

Please check if you have/had problems.

REVIEW OF SYSTEMS

MUSCULOSKELETAL

Rheumatoid Arthritis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Gout	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Osteoporosis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Weakness	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Spasm	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other _____				