Office Use Only:
□NP
□RP
□APPT

Please complete all applicable fields ***Date***: ______________________

--*DEMOGRAPHICS*--

Full Name:____ **DOB**:_______________________

Address: ____

City: _______________________________ **State**:_____________ **Zip Code**: ________________

Home phone:__________________ **Cell**:____________________ **Work phone**:________________

Employment: □Student □Employed □Unemployed □Retired **Occupation:**______________________

Job Start Date (approx):_____________________ **Job End Date (approx):**____________________

Social Security # :_____-_____-_____ **How did you hear about us?**:__________________________

Cell phone carrier (**for text messages**): □Verizon □Sprint □T-Mobile □AT&T Other:_____________

Contact Preference: □Home phone □ Cell □Work □Email **Email**:__________________________

Gender: □ Male □ Female **Marital Status**: □Single □Married □Widowed □Separated □Divorced

Name of spouse:_______________________ **Spouse phone number**:_________________________

Primary Language: □ English □□ Spanish Other:____

Race/Ethnicity: □White □Black/African American □Native Hawaiian/Other Pacific Islander □Asian

□American Indian or Alaska Native □Hispanic or Latino □Refuse to Declare

Primary Care Physician Name and Phone #:____

--*INSURANCE*--

Who is responsible for the bill? □Self □Medical Ins □Auto Ins □Attorney Other:________________

Insurance Company:___________________________ **Insurance Phone Number**:______________

ID/Claim #: ______________________________________ **Group #:**__________________________

Policy Holder name:____________________________ **Policy Holder DOB**: ___________________

Policy Holder relationship to patient: □Self □Spouse □Parent Other:________________________

Insurance Company Address:____

Insurance Company of the person at fault:_________________________ **Date of Injury:**__________

Adjuster Name and Phone number:____

Attorney Name and Phone number:____

ACTIVE FAMILY
CHIROPRACTIC

----------MEDICAL HISTORY----------

VITALS

For Office Use Only

Height_______________ **Weight**_______________ **Blood Pressure** _______________

MEDICATIONS

Please include over the counter medications, herbs and vitamins.

Date Started	Brand/Generic Name	Strength	Dosage	Frequency	Duration	Quantity

ALLERGIES

Allergy	Type	Reaction
______________	□Environment □Food □Medication	______________
______________	□Environment □Food □Medication	______________
______________	□Environment □Food □Medication	______________
______________	□Environment □Food □Medication	______________

SURGERIES

Date of Surgery	Surgery	Results

HOSPITALIZATION

Date of Hospitalization	Reason	Hospital

Have you been diagnosed with Diabetes? □ Yes □ No → □Type I □Type II

ILLNESS

Date of Major Illness	Illness

IMMUNIZATION

Date Administered	Vaccine	Reaction

FAMILY HISTORY

Relationship	Medical History/ Chronic Health problems	Deceased?	Cause of Death
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Maternal Grandparent			
Paternal Grandmother			
Paternal Grandfather			
Paternal Grandparent			

SOCIAL HISTORY

Who do you live with? □Alone □With spouse □With:______________________

Do you smoke? □Never smoked □Current smoker □Former smoker □Current every day smoker □Current some day smoker

Do you consume alcohol? □None □Casual drinker □Moderate drinker □Heavy drinker □Drinks beer □Drinks wine

Do you consume caffeine? □None □Less than 3 drinks/day □3-6 drinks/day □More than 6 drinks/day

Do you use drugs? □None □Recreational user □Addiction

Do you exercise? □Never □Daily □Weekly □Walks □Runs □Swims

Please complete all applicable fields and circle any answer that best describes how you are feeling.

SUBJECTIVE INFORMATION

Patient Name:__________________________________ **Date**: ____________________

Please give a brief description of the problem[s] you are experiencing:
____

Describe how the problem affects your daily activities: i.e. sitting, walking, house work, playing with kids etc.:
____

What date did the problem start? ____

Is/Are the problem[s] getting better? Yes No **or getting worse**? Yes No

What appears to be the initial cause? ____
____
____

Are you seeing any other providers for this or other problems or health conditions? Yes No
List the problem[s], date problem[s] began and Provider[s] treating you for the condition:
____
____

Complaint Location: ________________________**Which side?: right, left or bilateral**

Onset: Acute Chronic Gradual

Quality: Achy Dull Stiff Tight Sharp Throbbing

Current pain level: (Good) 0 1 2 3 4 5 6 7 8 9 10 (Bad)

Range: How does it feel at its best? (Good) 0 1 2 3 4 5 6 7 8 9 10 (Bad)

How does it feel at its worst? (Good) 0 1 2 3 4 5 6 7 8 9 10 (Bad)

Frequency: Constant Frequent Occasional Intermittent

Does the pain radiate or travel? Yes No **If yes, please explain here?**_____________
____

When is the pain worse? Morning As day progresses Afternoon Night No change

What makes it worse? Nothing Rest Sleep Walking Standing Bending Moving Driving Stress Sitting Other:________

When is the pain better? Morning As day progresses Afternoon Night (skip if doesn't change)

What makes it better? Nothing Rest Sleep Moving Ice Heat Medication Chiropractic Care Massage Sitting Lying Down Other:_____

Do you experience numbness? Yes No **If Yes, where**? ___________________________

Do you experience spasms? Yes No **If Yes, where**?____________________________

Do you experience weakness? Yes No **If Yes, where**?____________________________