Amory Chiropractic

New Patient Information

Personal Information

Patient Name_____ Date of Birth_____ Age____ Sex: M F

Address_____ City_____ State____ Zip_____

Phone_____ Social Security #_____ Marital Status: M S D W

Employer_____ Phone (Work)_____

Emergency Contact_____Relationship_____Phone_____

Spouse's Name_____ Phone_____

Spouse's Employer_____ Spouse's Phone (Work)_____

How did you hear about our office? _____

Present Condition due to an injury? Yes__ No__ On the Job__ Auto Accident__ Other_____

Has the Accident Been Reported? Yes__ No __ To Employer__ Auto Ins __ Other_____

Case History

Reason for seeking care:_____

List any other doctors seen for this:_____

List any diagnosis and type of treatment:_____

Have you had similar accidents or injuries before? Yes__ No__ If yes, explain:_____

Have you or any relative received chiropractic treatment before? Yes__ No__

If Yes, explain:_____

Have you been treated for any health condition by a physician in the last year? Yes__ No__

If Yes, explain:_____

Are you currently taking medication? Yes__ No__

If Yes, list medicine and condition

_____

_____

_____

Have you taken medication in the past? Yes__ No__

If Yes, list medicine and condition

_____

List any surgeries and dates_____

Family History: List Health Conditions, age at death, and cause of death.

Father: _____

Mother: _____

Sibling(s): _____

_____

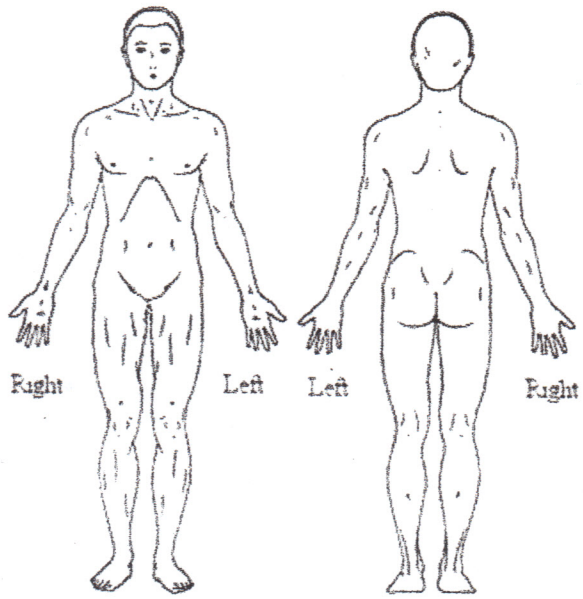
Do you smoke? Yes__ No__ Use Alcohol? No __ Daily __ Weekly __ Social Occasions __

On average, how many caffeinated drinks per day? ____

Do you take vitamins/supplements? If yes, what type and how often?_____

_____

_____



Please circle degree of pain. 0 = None, 10 = Severe

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	===
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins/Needles	+++
Other_____	^^^

What activities aggravate your condition? _____

What activities lessen your condition? _____

Condition worse during certain times of the day? Y/N

Is the condition interfering with Work? ____ Sleep?_____

Routine? _____ Other? _____

Is this condition progressively getting worse? _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient
Signature_____Date_____