



Patient Information

Full Name: _____ Age: _____ Birth Date: ____/____/____
Address: _____ Social Security No.: ____-____-____
City: _____ State: _____ Zip: ____-____ Number of Children: ____ Status: Married Divorced
 Single Widow
E-mail Address: _____ Referred by: _____
Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell/Other Phone: (____) ____-____
Employer: _____ Occupation: _____

I prefer to receive calls at:
HOME WORK CELL

Spouse's Information

Name: _____ Age: _____ Birth Date: ____/____/____
Employer: _____ Occupation: _____
Health Status: _____

Emergency Contact Name: _____ Contact Number: (____) ____-____

Payment Information

Person Responsible for Payment: _____ Social Security No.: ____-____-____
Contact Number: (____) ____-____ Birth Date: ____/____/____

Insurance Information Do you have health insurance? YES NO

Primary Insurance

Secondary Insurance

Insurance Company: _____ Insurance Company: _____
Policy Holders Name: _____ Policy Holders Name: _____
Relationship to Parent: _____ Relationship to Parent: _____
Policy Holder Birth Date: ____/____/____ Policy Holder Birth Date: ____/____/____
Group Number: _____ Group Number: _____
Policy ID Number: _____ Policy ID Number: _____

Chief Complaint(s):

Chiropractic History

#1 Complaint: _____
#2 Complaint: _____
#3 Complaint: _____
#4 Complaint: _____

Onset: Please Explain

When did the pain start? _____
 Specific Injury Over Time?



How would you rate the level of discomfort right now on a scale of 1 to 10? (10 = worst) _____

How frequently do you feel the discomfort?(Circle one) 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What makes the pain worse? (Circle all that apply)

bending cleaning cooking coughing dressing driving exercising kneeling lifting lying pulling pushing reaching
running sitting standing sneezing turning typing walking working other: _____

What makes the pain better? _____

Do you feel like this condition is getting worse? YES NO UNSURE

What does this pain feel like? (Circle all that apply)

Sharp Dull Burns Shooting Crushing Throbbing Achy Stiff Numb Tingling Other: _____

Does the pain move or radiate? YES NO If YES, describe: _____

Does the pain stop you from, or reduce, your ability to do any of your normal activities? YES NO

If YES, describe: SLEEP WORK RECREATION DAILY ROUTINE OTHER: _____

TIMING: Is the pain: (Circle all that apply)

CONSTANT BETTER IN AM INTERMITTENT WORSE IN AM WORSE IN PM

Has the pain ever occurred before? YES NO Number of times per week you have this problem _____

Have you seen other Doctors for THIS condition? YES NO

If yes, Name of Doctor(s): _____ Results: _____

Previous treatment(s) for this condition: (Circle all that apply)

OTC Meds RX Meds Chiropractic Physical Therapy Ice Heat Exercise Rest Other: _____

Have you ever been under Chiropractic care? YES NO If yes, Name of Doctor(s), date, and why: _____

Medical History

Date of last physical exam? ___/___/___ PCP Name: _____ Office #: (___) ___-___

List any conditions currently being treated for and diagnosis: _____

Previous surgeries? YES NO If yes, type & date: _____

Broken Bones? YES NO If yes, list location, cause, & date: _____

Been in an Auto Accident? YES NO If yes, explain & date: _____

Been struck unconscious? YES NO If yes, explain & date: _____

Had sprain or strain? YES NO If yes, explain & date: _____

Hospitalization? YES NO If yes, explain & date: _____

Major Accident or falls? YES NO If yes, explain & date: _____

MEDICATIONS: (List type, dosage, and reason) _____

Vitamins: _____

Habits: Circle level of usage

Alcohol NONE Light Moderate Heavy

Coffee NONE Light Moderate Heavy

Tobacco NONE Light Moderate Heavy

Drugs (Illegal) NONE Light Moderate Heavy

Exercise NONE Light Moderate Heavy

Sleep NONE Light Moderate Heavy

Soft Drinks NONE Light Moderate Heavy

Water NONE Light Moderate Heavy

Salty Foods NONE Light Moderate Heavy

Artificial Sweeteners NONE Light Moderate Heavy

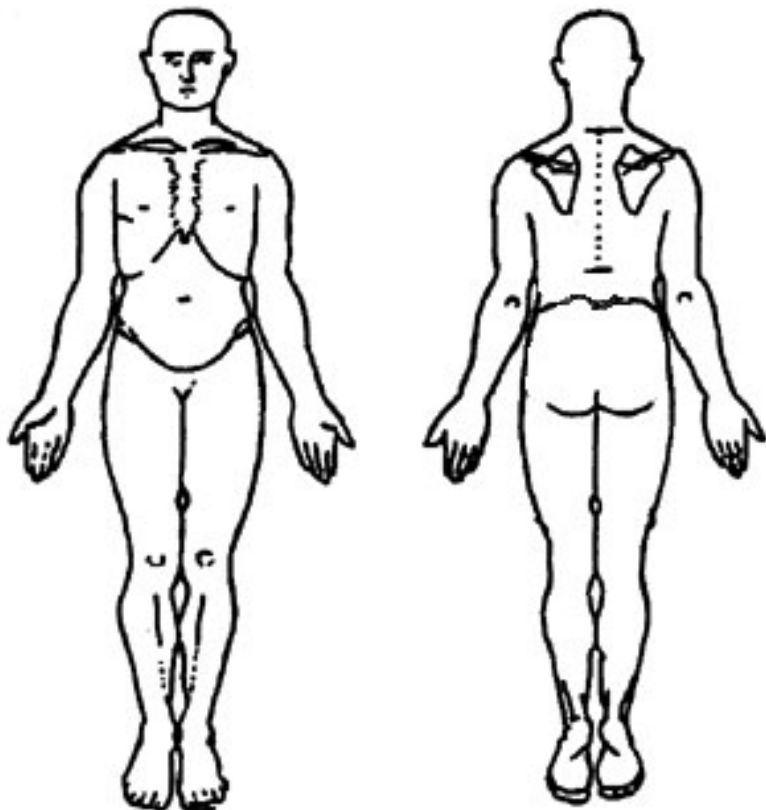


Circle any of the following you HAVE or HAVE HAD in the past: (circle all that apply)

Low Back Pain	Shoulder Pain	Neck Pain	Arm Pain	Joint Pain/Stiffness	Difficulty Walking	Clicking Jaw
TMJ	Bladder Trouble	Painful Urination	Nervousness	Numbness	Paralysis	Dizziness
Forgetfulness	Stress	Concussions	Cold/Tingling Extremities	Chest Pain	Short Breath	High Blood Pressure
Irregular Heartbeat	Heart Problems	Congestion/Lung Problems	Varicose Veins	Swelling	Fatigue	Fever
Headaches	Sleep Problems/Insomnia	Vision Problems	Dental Problems	Sore Throat	Hearing Problems	
Poor appetite	Excessive Appetite	Excessive Thirst	Frequent Nausea	Vomiting	Diarrhea	Constipation
Hemorrhoids	Liver Problems	Gall Bladder Problems	Heartburn	Gas/Bloating	Black/Bloody Stool	Colitis
Alcoholism	Anemia	Arteriosclerosis	Arthritis	Asthma	Breast Lump	Cancer
Hot Flashes	Irregular Cycle	Kidney Infection	Kidney Stones	Loss of Memory	Pacemaker	Polio
Sciatica	Sinus Infection	Scoliosis	Prostate Trouble	Thyroid Condition	Tuberculosis	Ulcers
Mental Disorder	Heart Attack	Venereal Disease	Sexual Dysfunction	Diabetes		

For Women: Date of last menstrual cycle: _____ Are you pregnant? YES NO _____

PAIN CHART



Mark areas of pain on the figure.

No Pain = 0 Worse = 10

Type of Pain: STIFFNESS BURNING
 NUMB/TINGLING SHARP SORENESS/ACHY

NECK PAIN

0 1 2 3 4 5 6 7 8 9 10

SHOULDER/ARM PAIN

0 1 2 3 4 5 6 7 8 9 10

MID BACK PAIN

0 1 2 3 4 5 6 7 8 9 10

LOW BACK PAIN

0 1 2 3 4 5 6 7 8 9 10

HIP/LEG PAIN

0 1 2 3 4 5 6 7 8 9 10

FOOT/ANKLE PAIN

0 1 2 3 4 5 6 7 8 9 10

HEADACHE PAIN

0 1 2 3 4 5 6 7 8 9 10

OTHER PAIN: _____

0 1 2 3 4 5 6 7 8 9 10

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release: By signing below, I authorize Effective Chiropractic to release Medical Records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Effective Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient which I am a gaurantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and/or health care operations.

By signing below, I give consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests, and procedures for the aforementioned minor.

Signed: _____ Date: _____

