

# A. Little Chiropractic Center

## DR. ALICIA LITTLE

1018 Ralston Avenue Suite 102

Defiance, OH 43512

419-782-2272

### Patient Information Form

Legal Name \_\_\_\_\_ Suffix \_\_\_\_\_ Preferred Name \_\_\_\_\_

Marital Status: Single Married Other Date of Birth \_\_\_\_\_ Sex: M or F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_

\*Pregnant: Yes No \*How many Pregnancies \_\_\_\_\_ \*Deliveries \_\_\_\_\_

Referred By \_\_\_\_\_ Appointment Reminder: (please circle one) Call Text None

Preferred Language \_\_\_\_\_ Dominant Hand: (please circle one) Right Left Ambidextrous

Race: (please circle one)

American Indian or Alaska Native

Asian

Hispanic or Latino

Black or African American

White

Decline to Specify/Other

Ethnicity: (please circle one)

Decline

Hispanic

Not Hispanic or Latino

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M or F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Job Status: (please circle one)

Employed

Not Employed

Full time Student

Part-time Student

Retired

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Job description \_\_\_\_\_

Work Schedule \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Fax \_\_\_\_\_ Work Email \_\_\_\_\_

Have you ever received chiropractic care?      Yes      No      How long ago? \_\_\_\_\_

Reason for seeking care now \_\_\_\_\_

Location of complaint \_\_\_\_\_

Complaint began when(date)? \_\_\_\_\_ How? \_\_\_\_\_

Have you had pain like this before? \_\_\_\_\_ When? \_\_\_\_\_

Please circle the description that best applies

Dull      Aching      Sharp      Shooting      Burning      Throbbing      Stabbing      Deep      Nagging

Does the pain radiate or travel to other areas of your body? \_\_\_\_\_ Where? \_\_\_\_\_

Do you have any numbness or tingling? \_\_\_\_\_ Where? \_\_\_\_\_

Please grade the intensity of **EACH** complaint:

No Pain      0      1      2      3      4      5      6      7      8      9      10      Worst possible pain

How often is the complaint present? \_\_\_\_\_

How long do episodes last? \_\_\_\_\_

Does anything make the pain worse? \_\_\_\_\_

Does anything make the pain better? \_\_\_\_\_

Do you notice the pain more in the:      Morning      Afternoon      Evening

Previous treatment for the complaint? \_\_\_\_\_

Primary Care Provider/Family Physician \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_

**Medications/Vitamins**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reason for taking Medicine**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Illnesses**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Surgeries (Body Part)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Traumas**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever broken any bones? Yes No Which? \_\_\_\_\_ When? \_\_\_\_\_

Health problems of immediate family \_\_\_\_\_

Cause of Death in immediate family:

Date

_____	_____
_____	_____
_____	_____
_____	_____

Level of Education: (please circle one)

High School

Some College

College Graduate

Post Graduate

Hobbies \_\_\_\_\_

Alcohol use: (Please circle one)

Never

Social (1-3 drinks/week)

Frequently (4-6 drinks/week)

Daily (7 or more)

Tobacco use: (Please circle one)

Never

Used to be

Casual

Heavy

Diet \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, in accordance with the state's statutes.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature (Minor's) \_\_\_\_\_ Date \_\_\_\_\_