Patient Infomation

(PLEASE PRINT)

New Patient _______
Reactivate _______
Date ____/____/____

Full Legal Name ____**Birth Date** ____/____/____
First Middle Last

Address ____
Street/PO Box City State Zip

Home Phone (_____) _____-_______ **Mobile Phone** (_____) _____-_______
Would you like to receive Text reminders for appointments? □ No □ Yes

E-mail Address ____________________@____________________
Communication Preference: □ **E-mail** □ **Phone** □ **Mail** □ **Patient Portal**

Employer ____ Work Phone (____) ______-________

Occupation ____ Student □ No □ Yes

Marital Status □ Single □ Married □ Separated □ Divorced □ Widowed

Spouse Name_________________ Phone (_____) ______-________ Spouse Employer_____________________

Emergency Contact ______________________ Phone (_____)_____-_____ Relationship ___________________

Did anyone refer you to our office? □ No □ Yes- Name_______________________________________

History of Present Illness/Injury:

What are your symptoms? ____

Date your symptoms began _____/_____/_____

How did it occur? ______________________________________ □ *Work Related □ *Auto Accident
(*Please provide copies of ALL Documents*)

Have you missed any work? □ No □ Yes- How Much? ________________hours/days/weeks/months

Do you have any x-rays of that area(s)? □ No □ Yes –Facility where taken? _______________________

Clinic Use Only: _____HIPPA Signed _____Informed Consent Signed _____Office Policy

Patient Infomation

Patient Demographics (*Required per Federal Regulations)

SSN#_________-_________-_________

*Gender □ Male □Female

*Ethnicity (select one): □ Hispanic □Not Hispanic

*Race (select one): □ Alaska Native □Asian □Native Hawaiian □White/Caucasian □Other

*Language (select one): □ English □ Spanish □ Other__________

Allergies □ None -OR- □ See List Below

Drug/Medication	Food:	Other Allergies (e.g.-animals, pollen, latex, etc.)
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________

Current Prescription Medications □ None –OR- See Below

Name of Prescription	Dose (mg, ml, etc.)	Form (tabs, caps, etc.)	Duration (# times/day, wk, mo)
_______________________________	__________	____________	_________________
_______________________________	__________	____________	_________________
_______________________________	__________	____________	_________________
_______________________________	__________	____________	_________________
_______________________________	__________	____________	_________________

Family Health History

List any current or past health conditions of your family members (*if deceased, indicate at what age and what from)

Mother: ____

Father: ____

Brothers: ____ How many _____

Sisters: ____ How many _____

Children: ____How many _____

____I choose to decline receipt of my clinical summary after every visit (These are often blank due to nature and frequency of chiropractic care)

Notes:____

Height:____'____" Weight:_______lbs. Pulse:_______ Blood Pressure:______/______ Temp: ______

ARCADIA CHIROPRACTIC & WELLNESS

Patient Infomation

History of Present Illness- Chief Complaint(s) (see also page 1)

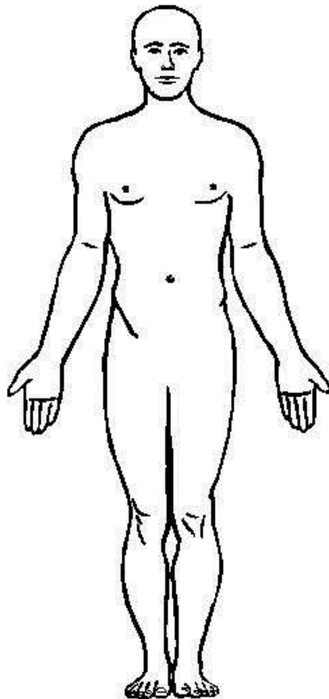
Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale from 0-100 (0=no pain, 100=intolerable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next to each area as appropriate.

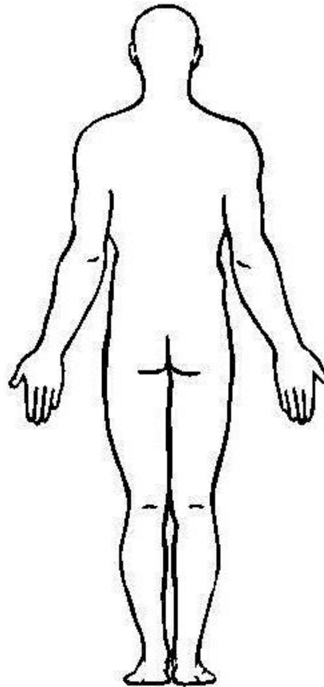
X X X = Burning pain
(((= Aching pain
0 0 0 = Pin & Needles
---- = Numbness
: : : = Sharp Pain

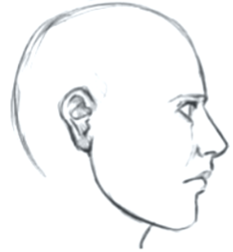
_____Constant
_____Comes/Goes

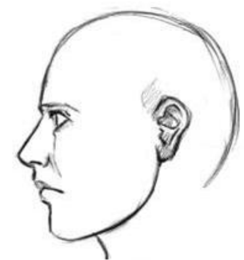
_____Getting better
_____Getting worse
_____Staying same

Better		**Worse**
_____	AM	______
____	MID-DAY	_____
_____	PM	______









No Pain **Pain Scale:** Intolerable

0_______1 _________2_________3_________4_________5_________6_________7_________8_________9_______10

What makes condition **BETTER**?

Head/Neck: ____Heat ____Cold ____Meds ____Chiropractic ___Other: ________________________
Mid Back: ____Heat ____Cold ____Meds ____Chiropractic ___Other: ________________________
Low Back: ____Heat ____Cold ____Meds ____Chiropractic ___Other: ________________________
Shoulder, Arm, Wrist, Hand: ____Heat ____Cold ____Meds ____Chiropractic ___Other: ________________________
Hip, Leg, Ankle, Foot: ____Heat ____Cold ____Meds ____Chiropractic ___Other: ________________________
Other: ________________ ____Heat ____Cold ____Meds ____Chiropractic ___Other: ________________________

What makes condition **WORSE**? (What activities, movements, etc.)

Head/Neck: ____
Mid Back: ____
Low Back: ____
Shoulder, Arm, Wrist, Hand: ____
Hip, Leg, Ankle, Foot: ____
Other: ________________ ____

Indicate your ability to perform the following activities of daily living. Please use the following codes & Rate from 0-10:

U-Unable L-Limited P-Painful D-Difficult N-Normal H-Haven't tried

____Lying on back ____Dressing self ____Gripping ____Kneeling ____Twist/turn-**Left/Right**
____Lying on side ____Stooping ____Lifting ____Bending forward ____Sitting/Driving/Riding
____Lying on stomach ____Pushing/Pulling ____Standing ____Get in/out of car ____Using computer
____Turning over in bed ____Reaching ____Walking ____Sexual activity ____Using stairs
____Cough/sneeze/grunt- (if painful, where ____)
____Sleeping- (# of times you wake up_______; # pillows______; position slept in______________________________)

Does your pain radiate? □ No □ Yes ___________________
Do you have any loss of strength? □ No □ Yes_____________

ARCADIA CHIROPRACTIC & WELLNESS

Patient Infomation

Past Medical History

FEMALES: Are you pregnant? □ No □Yes- Due Date _____/_____/_____ Doctor ___________________

Date of last Gynecological & Breast Exam ______/______/______

MALES: Date of last Prostate & Testicular Exam ______/______/______

How often have you had this condition that you are seeing us today for? □ Never □ 1-3 times □ 4 or more

Have you received care from a Chiropractor before? □ No □ Yes

Have you seen a Medical Doctor for this Condition? □ No □ Yes- Doctor/Clinic ______________________

Do you have any other Health Conditions? (Check all that apply)

□ Diabetes □ High Blood Pressure □ High Cholesterol □ Asthma □ IBS/Colitis

□ Cancer □ Arthritis □ Infertility Issues □ Other __________________________

Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents or Surgeries

Date	Doctor/Facility	Condition(s)/Procedure	
____/____/____	________________________	_______________________	____Full recovery ___Complications
____/____/____	________________________	_______________________	____Full recovery ___Complications
____/____/____	________________________	_______________________	____Full recovery ___Complications
____/____/____	________________________	_______________________	____Full recovery ___Complications

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Social Health History

Recreational Activities/Hobbies ____

Do you exercise? □ No □ Yes- How often? _______________ In what way? _________________________

Do you consume caffeine? □ No □ Yes –How much? _______________ How often? ________________

Do you consume alcohol? □ No □ Yes- How much? ________________ How often? ________________

Smoking Status (Individuals age 13 years and older):

□ Smoker-Daily (___Packs/day or ____ Cigarettes/day- for: ___Years or since ____/____/____)

□ Smoker-Some Days (NOT Daily)

□ Ex-Smoker (____Packs/day or ____Cigarettes/day-from: Age ____ to ____)

□ Never

□ Smoker-Current Status Unknown

System Review Questions

Have you had any problems with the following areas now or in the past? (Y=Yes, N=No)

____**Eyes** (Glasses, Contacts, Cataracts, Glaucoma, etc.)

____**Ears, Mouth, Nose, Throat** (Hearing Loss, Sinus, etc.)

____**Cardiovascular** (Heart, High BP, High Cholesterol, etc.)

____**Respiratory** (Lungs, Breathing, Asthma, COPD, etc.)

____**Neurological** (Nerve Issues, Weakness, Numbness, etc.)

____**Endocrine** (Thyroid, Hormonal, Imbalances, Liver, etc.)

____**Gastro-Intestinal** (Acid Reflux, Ulcers, Gall Bladder, IBS, etc.)

____**Genitourinary** (Male/Female Reproductive, Kidney, Bladder, etc.)

____**Musculoskeletal** (Breaks, Arthritis, Osteoporosis, Discs, etc.)

____**Skin** (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, etc.)

____**Psychiatric** (Anxiety, Depression, Bipolar, ADD/ADHD, etc.)

____ **Other** ____