DATE: _______________ **SUNSHINE CHIROPRACTIC** CHART: _______________

Patient Name:_______________ Birthdate: _______________ Age: _______

Address:_______________ City: _______________ State: _________ Zip: __________

Home Phone: _______________ Work Phone: _______________ Cell Phone: _______________

SS #:_______________ Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Email: _______________ Referred By: _______________

Occupation: _______________ Employer: _______________

Spouse Name: _______________ Spouse Birthdate: _______________ Spouse SS #: _______________

Emergency Contact: _______________ Relation: _______________ Phone #: _______________

Patient Complaints: _______________

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_______________

Date Symptoms Began _______________

How Problem Began _______________

Is this ☐Work Related ☐Auto Related ☐Unknown

SSS=Stabbing

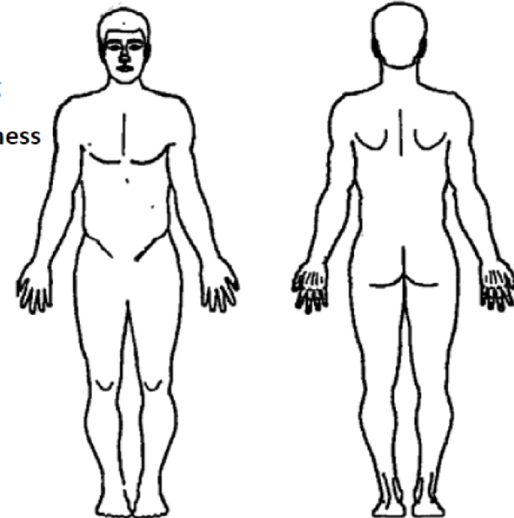
PPP=Pins & Needles

AAA=Aching

BBB=Burning

NNN=Numbness

Place symbol on Pain Area



Current Complaint (How You Feel Today)

0 1 2 3 4 5 6 7 8 9 10

No Pain ... Unbearable Pain

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities or household chores)

0 1 2 3 4 5 6 7 8 9 10

No Interference ... Unable to carry on activities

How often are your symptoms present? ( 0-25% 26-50% 51-75% 76-100% ) (Day or Week)

What Makes Your Condition Better? ☐Exercise ☐Heat ☐Ice ☐Lying Down ☐Medications ☐Rest ☐Sitting ☐Standing ☐Stretching

What Makes Your Condition Worse? ☐Bending ☐Coughing ☐Lifting ☐Sitting ☐Sneezing ☐Standing ☐Walking

Please check all of the following that apply to you:

☐Recent Fever
☐Diabetes
☐High Blood Pressure
☐Stroke Date__________
☐Use Cortisone/Prednisone
☐Taking Birth Control Pills
☐Dizziness/Fainting
☐Numbness in Groin/Buttocks
☐Cancer/Tumor ___________
_______________

☐Prostate Problems
☐Menstrual Problems
☐Urinary Problems
☐Pregnant #Weeks ____
☐Abnormal Weight ☐Gain ☐Loss
☐Morning Pain/Stiffness
☐Pain Unrelieved by Position or Rest
☐Pain at Night
☐Visual Disturbances
☐Epilepsy/Seizures

Please check all that apply to your family History:

☐Cancer ☐Diabetes ☐Heart Problems
☐Stroke ☐Rheumatoid Arthritis
☐High Blood Pressure

Other Health Problems

_______________

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