Andrew Chiropractic & Acupuncture Clinic, PA 330 N. First Street, Albemarle NC 28001 704-983-3552

Today's Date: ___________________

Patient Name:

Name patient wishes to be called:

Home Phone:

Cell Phone:

Work Phone:

Mailing address:

City: State: Zip Code:

Street Address *(if different than mailing address):*

City: State: Zip Code:

Email Address:

Gender: Male Female

Date of Birth:

Employer:

Emergency contact's name : Phone:

Guardian's Name *(if applicable):*

Spouse's Name: Date of Birth:

Spouse's Employer:

Insured Name *(as it appears on insurance card)*:

Member Insurance ID or Policy number:

Group Number:

Insurance Phone Number:

Thank you!

	Yes	No	Unsure	Patient Name: ____ **Please give details (dates, etc.). Use the "Additional Info" at the bottom of page if you need more space.**
Past History				Prior major illnesses and/or injuries?
				Prior surgeries/operations?
				Prior Hospitalizations?
				Taking any medications, supplements or herbs? Please list:
				Brittle bones (Osteoporosis)?
				Scoliosis (spine curvature)?
				Bleeding disorders and/or taking blood thinning medication (e.g. aspirin, etc.)?
				Diabetes?
Family/Soc. Hx				Family history of cancer, heart disease, diabetes, and /or risk of possible family hereditary conditions?
				Married? If no, are you? single separated divorced widowed
				Use? Alcohol Tobacco Recreational Drugs. If yes to any, what frequency and quantity:
Syst. Rev				Cardiovascular Problems (e.g. chest pain, palpitations, dizziness)?
				Trouble urinating?
				Dizziness?
				Blurred or double vision?
				Joint replacements?

How do you rate your overall health? Excellent Good Fair Poor

Chief Complaint *(If unsure of answer, leave blank)*	
	Please list your major complaint **only** (e.g. Low Back Pain, Headache, etc.):
	What caused this condition, if known?
	Date that it began, if known:
	On a 1 to 10 scale (10 being most severe): 1 2 3 4 5 6 7 8 9 10
	How often do you feel it? Constantly Frequently Occasionally Intermittently
	How has this complaint changed since the onset? Worsened Remained the Same Improved
	What makes this condition worse?
	What improves this condition or gives you relief?
	What activity of daily living is most affected by this condition? (e.g. lifting, driving, working, etc.):
	Are you taking any medication for this condition? (e.g. Tylenol, etc.)
	Any professional treatments have you received for this condition? (e.g. MD, Massage, PT)
Additional Info	