A. Little Chiropractic Center

DR. ALICIA LITTLE

1018 Ralston Avenue Ste 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____________________

Medication/Vitamins	**Reason for taking medication**	**Allergies**

Current Illnesses	**Past Surgeries (Body Part)**	**Year**	**Traumas**

Have you ever broken any bones? Yes No Which Bone?_________________ 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__________