A. Little Chiropractic Center

DR. ALICIA LITTLE

424 East Second Street
Defiance, OH 43512
419-782-2272

Patient Information Form

Legal Name_____ Suffix_____ Preferred Name_____

Address_____City_____State_____Zip_____

Cell Phone_____ Home Phone_____ Email_____

Date of Birth_____ Marital Status: Single Married Other

Sex at Birth: M or F Gender Identity: M or F

**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 Native Hawaiian or Pacific Islander

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_____