☐ New Patient Date_____

☐ Reactivation

Full Legal Name_____ Birth Date_____

Address_____

Home Phone_____ Mobile Phone _____Daytime/Work Phone_____

Employer_____Job Title_____

Marital Status __Single __Married __Divorced __ Widowed

Spouse Name_____ Phone #_____Spouse Employer _____

Emergency Contact_____Phone #_____Relationship _____

How were you referred to our office? __ MD __ Insurance __Health Fair /Talk __ Another CCW Patient _____

PATIENT DEMOGRAPHICS (*Required per Federal Guidelines)

SSN _____-___-_____ *Gender __Male __Female

*Ethnicity (select one) __ Hispanic __ Not Hispanic _____

*Race __ Alaska Native __Asian ___Native Hawaiian __ White/Caucasian

__ American Indian __Black/African American ___Other Pacific Islander __ Other_____

*Primary Language (select one) __English __Hmong __Lao __Spanish __Vietnamese __ Other_____

*Allergies __None or __See List Below

Drug/Medication/ADR _____

Food: _____

Other Allergies (e.g. dust, pollon, animals) _____

***Smoking Status (Individuals age 13 years and older)**

__Never

__Current Smoker, daily (___Packs/day or ____Cigarettes/Day for ___Years or since ___/___/____)

__Current Smoker, some days (NOT daily)

__Former Smoker (___Packs/day or ____Cigarettes/Day from Age___ to Age___)

__Smoker, current status unknown

***Current Medications Prescription/Non-prescription** ___None or ___See List Below

Name of Prescription	Dose	Form	Frequency	Chronic	As Needed	Unknown
_____	_____	_____	____X per _____	_____	_____	_____
_____	_____	_____	____X per _____	_____	_____	_____
_____	_____	_____	____X per _____	_____	_____	_____
_____	_____	_____	____X per _____	_____	_____	_____
_____	_____	_____	____X per _____	_____	_____	_____
_____	_____	_____	____X per _____	_____	_____	_____

HISTORY OF PRESENTING ILLNESS/INJURY

What are your symptoms? _____

Date symptoms began? _____How did it occur? _____

___ Work Related ___ Auto Accident Related Missed work or school? __No __Yes, how many days?_____

Have you tried any self-remedies, ice, heat, massage, etc._____

Have you seen any other providers for the condition you are seeing us today? _____

Have you received any prior treatment for this condition? _____

Have you ever seen a chiropractor before, if so, whom?_____

How many times have you had this condition previously? Never 1-3 times 4+ times

Have you had recent x-rays or other imaging of the area, if so, where were they taken? _____

Do you have any other health conditions? Please circle all that apply.

Diabetes High Blood Pressure High Cholesterol Asthma IBS/Cholitis Cancer

Arthritis Infertility Issues Other_____

Females: Are You Pregnant? ___ No ___ Yes , Estimated Due Date? _____

Describe any major illnesses, accidents, injuries, hospitalizations, or surgeries

Date	Doctor/Hospital	Condition(s)	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Occupation _____ Hours per week _____

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? _____

FAMILY HISTORY List any current or past health conditions of your family members. (if deceased, list age and cause of death)

Father _____

Mother _____

Brothers _____ How Many? _____

Sisters _____ How Many? _____

Children _____ ___ How Many? _____

SYSTEM REVIEW QUESTIONS Have you had any problems with the following areas, now or in the past? **Circle specific issues.**

__EYES (GLASSES, CONTACTS, CATARACTS, GLAUCOMA, ETC.)

__EARS, MOUTH, NOSE, THROAT (HEARING LOSS, SINUS, ETC.)

__CARDIOVASCULAR {HEART , HIGH B.P., HIGH CHOLESTEROL, STROKE)

__RESPIRATORY (LUNGS, BREATHING, ASTHMA, C.0.P.D., ETC.)

__NEUROLOGICAL {NERVE ISSUES, M.S., WEAKNESS, NUMBNESS, ETC.)

__ENDOCRINE (THYROID, HORMONAL IMBALANCES, LIVER, ETC.)

__INTERNAL ORGANS (DIABETES, APPENDIX, SPLEEN, LIVER, ETC.)

__GASTRO-INTESTINAL (ACID REFLUX, ULCERS, GALL BLADDER, IBS, ETC.)

__GENITO-URINARY (MALE/FEMALE REPRODUCTION, KIDNEYS, BLADDER, ETC.)

__ MUSCULOSKELETAL (BREAKS, ARTHRITIS, OSTEOPOROSIS, DISCS, ETC.)

__SKIN (RASHES, SKIN CANCER, DRYNESS, PSORIASIS, ECZEMA, HAIR, ETC.)

__PSYCHIATRIC (ANXIETY, DEPRESSION, BIPOLAR, ADD/ADHD, ETC.)

__CONSTITUTIONAL (FEVER, CHILLS, NAUSEA, DIZZINESS, ETC.)

__ HEMATOLOGICAL (ANEMIA, THIN BLOOD, SICKLE CELL, ETC.)

OTHERS:_____

HISTORY OF PRESENT ILLNESS - CHIEF COMPLAINT(S)

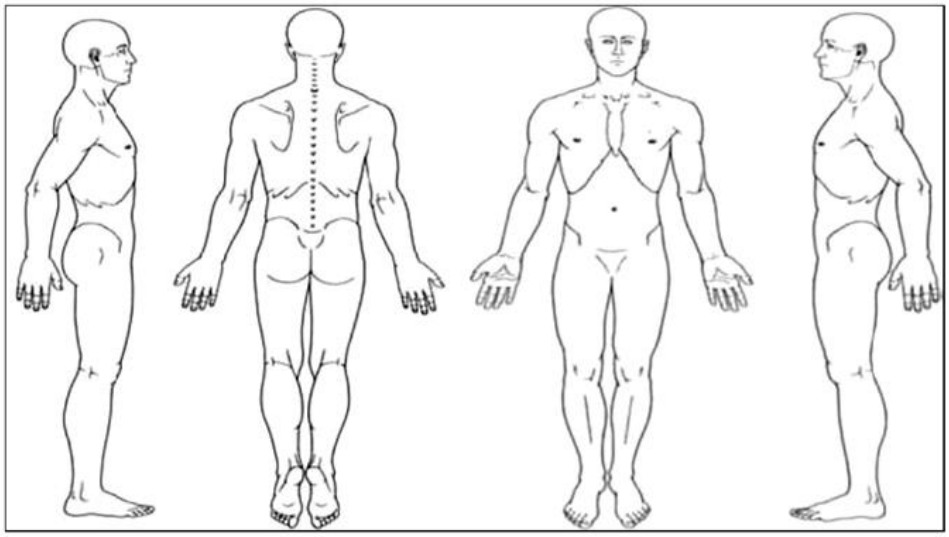
Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale below from 0 to 100 (0 = no pain; 100 = intolerable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next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

X X X Burning Pain
_(((Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
_: : : Sharp Pain

__ Constant
__ Comes/Goes
__ Fluctuates

__ Getting Better
__ Getting Worse
__ Staying Same

Better: Worse:
___ AM ___
___ MID-DAY ___
___ PM ___



NO PAIN PAIN SCALE: INTOLERABLE

0 __ 5 __ 10 __15 __ 20 __ 25 __ 30 __ 35 __ 40 __ 45 __ 50 __ 55 __ 60 __ 65 __ 70 __ 75 __ 80 __ 85 __ 90 __ 95 __ 100

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?

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:
U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

___ Lying on Back ___ Dressing Self ___Lifting ___Kneeling ___ Twist/Turn – LEFT / RIGHT
___ Lying on Sides ___ Stooping ___Gripping ___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 - (# times wake up _____ ; # pillows _____; position sleep in: _____)

Notes