McFerson CHIROPRACTIC

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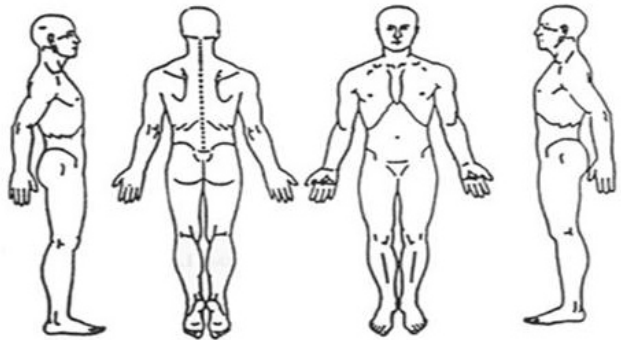
Patient Information

Patient's Name: _____ Date: _____
Patient's Guardian Name (if applicable): _____
Date of Birth: _____ Age: _____ Preferred Gender Pronoun: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Email: _____
Marital Status: _____ # of Children: _____Occupation: _____
What do your daily work habits include? (ex. Sitting, standing, lifting)_____
Person to contact in case of emergency: _____ Phone: _____
Primary Healthcare Provider and/or Clinic: _____ Phone: _____
Are you on Medicare/Medicaid: Yes/No Monthly Update Email (changes to hours, events, etc): Yes/No
Who may we thank for referring you? _____

Present Condition

What is the reason for your visit today? _____
Was there a triggering event? _____
When did you first notice the symptoms? _____
How are your symptoms changing? Getting Better Not Changing Getting Worse
What activities are difficult to perform? _____
Where specifically is the problem(s) located? _____

Please mark an X on the picture where you have pain, numbness, or tingling.



Type of pain (circle all that apply): Sharp Dull Throbbing Numbness Aching
Shooting Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain on scale from 1 (least) to 10 (severe pain): _____
How often do you have this pain (frequency and duration)? _____
Does it interfere with your: (circle all that apply) work sleep daily routine recreation
Have you received treatment for this condition? If yes, by whom? Was it helpful? _____

Health History

Please list any signification traumas or injuries you have had: _____

_____

Please list any major past illnesses, surgeries, or hospitalizations: _____

_____

Please list Medication/Supplements/Vitamins you are taking: _____

_____

Past medical history: _____

_____

Please list Allergies (medications, food, and environmental): _____

Exercise: Y/N Safe at home: Y/N Alcohol consumption: Y/N ___drinks/wk

Tobacco use: Y/N Sleep ____hours/night Drink_____ glasses water/day

Hobbies & Interests (what you do for fun): _____

_____

Please circle any complaints you have presently or have had in the past:

General	Fatigue, fever, chills, weight loss/gain, Sleep disturbance	Ears/Eyes/ Nose/Throat	Headache, dizziness, hearing loss, Sinus problems, Change in vision
Lungs	Difficult breathing, asthma, wheezing, persistent cough	Skin	Rash, bruising, hair loss, brittle nails
Cardiovascular	Chest pain, palpitations, ankle swelling, high/low blood pressure	Neurologic	Seizures, strokes, tingling/numbness, weakness, poor coordination, Difficulty walking
Muscle/Bone	Osteoporosis, arthritis, joint pain, stiffness, muscle ache, bone pain, fractures, dislocations	Psychologic	Excessive stress, Depression, Anxiety, Mood Swings
Family History	Cancer, Alcoholism, Depression, Heart Disease, Diabetes	OB GYN (females)	Pregnancy Y/N __# kids, Irregular periods, PMS, menopause

Have you seen a Chiropractor before? Who did you see? When? Was it helpful? _____

_____

What are your goals for your treatment? Short term? Long term? _____

_____

What else would you like us to know? _____

Patient/Patient Guardian Signature: _____ Date: _____

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