

OFFICE USE ONLY
Patient Number: _____
Diagnostic Code: _____

PATIENT ENTRANCE FORM

PATIENT INFORMATION

Last Name:		Middle Initial:		First Name:	
Preferred Name:					
Home Address:		City:		Postal Code:	
Age:		Birthdate:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> O
Would you like to receive our email newsletter? <input type="checkbox"/> Y			Email Address: _____		

PATIENT CONTACT INFORMATION

Patient Home #:		Patient Work #:		Patient Cell #:	
Emergency Contact Name:				Relationship:	
Home Phone:		Work Phone:		Cell Phone:	
Family Doctor:				Phone:	

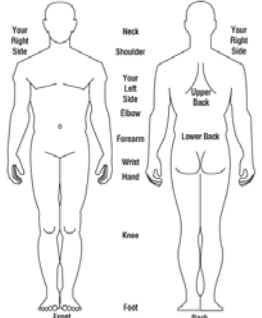
PATIENT EMPLOYER / SCHOOL INFORMATION

Please check one: <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other:					
Address:		City:		Postal Code:	
Phone:		Occupation:			

REFERRAL INFORMATION

How did you hear about our office? (please check one of the following)					
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> Sign <input type="checkbox"/> Website <input type="checkbox"/> Web Search <input type="checkbox"/> Other:					
Referred by: <input type="checkbox"/> Doctor <input type="checkbox"/> Patient <input type="checkbox"/> Family Member	Name: _____				

PATIENT CONDITION

Reason for Visit:					Mark an X to identify pain location:
When did symptoms appear?					
Is condition getting progressively worse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown		
Rate the severity of your pain from 1 (least) to 10 (severe)					
Type of Pain:	<input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Tingling <input type="checkbox"/> Swelling	<input type="checkbox"/> Throbbing <input type="checkbox"/> Cramps <input type="checkbox"/> Shooting	<input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Other	
How often do you have this pain?					
Is it constant or does it come & go?					
Does it interfere with your	<input type="checkbox"/> Work	<input type="checkbox"/> Sleep	<input type="checkbox"/> Daily Routine	<input type="checkbox"/> Recreation	
Activities or movements that are painful to perform:	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking	<input type="checkbox"/> Bending	<input type="checkbox"/> Lying Down

HEALTH HISTORY

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Services None Other

Name and address of Doctor(s) who have treated your condition:

Are you pregnant?

Yes No

Due Date:

Date of Last:

Physical Exam

Spinal X-ray

Blood Test

Spinal Exam

Chest X-ray

Urine Test

MRI/CT Scan

Bone Mineral Density Test

Please check the appropriate box if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Other |

ACCIDENT

Is condition due to an accident?

Yes No

Date:

Type of accident:

Auto Work Home Other

Accident Reported to:

Auto Insurance Employer Workers Comp Other

Attorney Name (if applicable):

WORK ACTIVITY

Sitting

Standing

Light Labor

Heavy Labor

HABITS

Smoking Packs/Day:

Alcohol Drinks/Week:

Coffee/Caffeine Drinks Cups/Day:

High Stress Level Reason:

INJURIES/SURGERIES

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/SUPPLEMENTS

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature:

Date:

Patient Parent Spouse