

CRAVEN CHIROPRACTIC CLINIC PATIENT INFORMATION

Name: _____ Date: _____ CASE # _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

What number do you prefer we reach you at? Home Work Cell

Email Address: _____ Occupation: _____

Marital Status: Married Single Spouse's Name: _____

HOW WERE YOU REFERRED TO US: GOOGLE SEARCH WEBSITE NEWSPAPER AD LOCATION

INSURANCE COMPANY REFERRED BY (Patients name:) _____

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holders Name: _____ DOB: _____

Social Security # of policy holder: _____ - _____ - _____

List any **Allergies**:

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen
 Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

List any **Surgeries**:

- Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist/Hand
 Other: _____

List **ALL Past Medical History** conditions:

- Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
 Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
 Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
 Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
 Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
 Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
 Stroke/Heart Attack Other: _____

List all the **NAME OF ALL MEDICATIONS AND THE REASON** you are currently taking: (Example: Ibuprofen – Pain)

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

Are you allergic to any medications: No Yes _____

Do you take any nutritional supplements? If so please list: _____

List your Family History:

- Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition
- High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio
- Prostate Problems Stroke/Heart Attack

Please list all family members who had/has any of the problems above: Example: Grandmother – High blood pressure

Have you had any auto or other accidents in the past? No Yes When did this occur? _____

Describe: _____

What was date and reason for last physical examination?: _____

Do you smoke? No Yes –How many per day? _____ If no were you a former smoker? No Yes

Do you drink alcohol? No Yes - how many per day/week? _____

Do you drink caffeine? No Yes - how much per day? _____

Do you exercise? No Yes (what forms and how often): _____

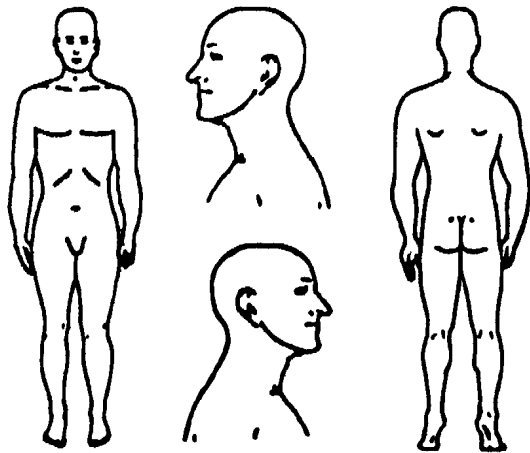
Have you ever had chiropractic care? Yes No Where? _____

Reason for care ? _____ When was your last visit? _____

What was done on your visits and how did you respond? _____

Were X-Rays taken? Yes ___ No ___

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reasons for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity

What concerns you the most? _____

PAGE 3 PATIENT NAME: _____ DATE: _____

What is your **PRIMARY** complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your **SECOND** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

PAGE 4 PATIENT NAME: _____ DATE: _____

What is your **third** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your **fourth** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Are there any other complaints or issues we need to discuss at this time?

Signature _____ Date _____