## Patient Data Date: _____

**Title:** ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one)

**First Name:** _____ **Middle Initial:** _____ **Last Name:** _____

**Nickname:** _____ **Date of Birth:** _____/_____/_____ **Sex:** ☐Male ☐Female

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Home Phone:** (_____)_____-_____ **Work Phone:** (_____)_____-_____

**Cell Phone:** (_____)_____-_____ **Email:** _____

**Social Security Number:** _____-_____-_____ **Marital Status:** ☐Single ☐Married ☐Other

**Employment Status:** ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

## Spouse Data

**Is your spouse a patient in the clinic?** ☐Yes ☐ No **Occupation:** _____

**First Name:** _____ **Middle Initial:** _____ **Last Name:** _____

**Cell Phone:** (_____) _____-_____ **Email:** _____

**Spouse's Date of Birth:** _____/_____/_____ **Spouse's SS#:** _____-_____ -_____

## Employer Data

**Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

## Insured's Data

**Insured's Full Name:** _____ **SS#:** _____-_____-_____

**Insurance Company:** _____ **ID#:** _____

**Policy Holder's Name:** _____ **Relationship to insured:** _____

**Employer:** _____

## Emergency Contact

**Contact Name:**_____ **Contact Phone:** (_____) _____-_____

**Is it okay to call you at work?**
❑ Yes ❑ No

**How did you hear about our clinic? Or who referred you?**

| | | | |
|---|---|---|---|
| ❑ Family member | ❑ Attorney | ❑ Internet web site | ❑ Health class |
| ❑ Friend | ❑ Yellow Pages | ❑ Billboard | ❑ Brochure |
| ❑ Physician | ❑ Newspaper ad | ❑ TV Commercial | ❑ Direct mail ad |
| ❑ Employer | ❑ Sign on building | ❑ Radio | ❑ Other |

**If you selected 'Yellow Pages' please indicate which Yellow Pages:**

HTC-_____ Verizon-_____ AT&T-_____ Other-_____

**If you selected 'family member', 'friend', or 'physician' please enter their name below:**

_____

**If you selected 'other' please describe**

_____

**Medical Conditions:**

| | | | |
|---|---|---|---|
| ❑ Arthritis | ❑ Cancer | ❑ Diabetes | ❑ Heart Disease |
| ❑ Hypertension | ❑ Psychiatric Illness | ❑ Skin Disorder | ❑ Stroke |

Other:_____

**Surgeries:**

| | | | |
|---|---|---|---|
| ❑ Appendectomy | ❑ Cardiovascular procedure | ❑ Cervical disc procedure | ❑ Hysterectomy |
| ❑ Joint replacement | ❑ Laminectomies | ❑ Radical prostatectomy | ❑ Transuretheral prostate surgery |

Other:_____

**Allergies:**

| | | | |
|---|---|---|---|
| ❑ Eggs | ❑ Fish and Shellfish | ❑ Milk or Lactose | ❑ Peanut |
| ❑ Soy | ❑ Sulfites | ❑ Wheat/Gluten | ❑ Other_____ |

**Social History:**

| | | | |
|---|---|---|---|
| ❑ Caffeine used occasionally | ❑ Caffeine used often | ❑ Chew tobacco occasionally | ❑ Chew tobacco often |
| ❑ Drink alcohol occasionally | ❑ Drink alcohol often | ❑ Exercise not at all | ❑ Exercise occasionally |
| ❑ Exercise often | ❑ Experience stress occasionall | ❑ Experience stress often | ❑ Smoke 1 pack or less per day |
| ❑ Smoke + 1 pack a day | ❑ Wear seat belts always | ❑ Wear seat belts never | ❑ Wear seatbelts usually |

**Family History:**

| | | | |
|---|---|---|---|
| ❑ Arthritis (parent) | ❑ Arthritis (sibling) | ❑ Cancer (parent) | ❑ Cancer (sibling) |
| ❑ Cholesterol (parent) | ❑ Cholesterol (sibling) | ❑ Diabetes (parent) | ❑ Diabetes (sibling) |
| ❑ Heart problems (parent) | ❑ Heart problems (sibling) | ❑ High blood pressure (parent) | ❑ High blood pressure (sibling) |
| ❑ Psychiatric (parent) | ❑ Psychiatric (sibling) | ❑ Stroke (parent) | ❑ Stroke (sibling) |
| ❑ Thyroid (parent) | ❑ Thyroid (sibling) | ❑ Other _____ | ❑ Other _____ |

**Substance Use:**

| | | | |
|---|---|---|---|
| ❑ Alcohol (past) | ❑ Alcohol (present) | ❑ Amphetamines (past) | ❑ Amphetamines (present) |
| ❑ Barbiturates (past) | ❑ Barbiturates (present) | ❑ Cocaine (past) | ❑ Cocaine (present) |
| ❑ Crystal Meth (past) | ❑ Crystal Meth (present) | ❑ Heroine (past) | ❑ Heroine (Present) |
| ❑ Marijuana (past) | ❑ Marijuana (present) | ❑ Other _____ | ❑ Other _____ |

**Medications (please list):**_____

**Are you pregnant or think there is a chance that you may be pregnant?** ❑ Yes ❑ No

**Male Children:** How many male children do you have? _____ Have they ever been under chiropractic care? _____

| | | | |
|---|---|---|---|
| ❑ Under 6 years | ❑ Under 10 years | ❑ Under 19 years | ❑ Over 19 years |

**Female Children:** How many female children do you have? _____ Have they ever been under chiropractic care? _____

| | | | |
|---|---|---|---|
| ❑ Under 6 years | ❑ Under 10 years | ❑ Under 19 years | ❑ Over 19 years |

**Occupational Activities:**

| | | | |
|---|---|---|---|
| ❑ Administration | ❑ Business owner | ❑ Clerical/secretarial | ❑ Computer user |
| ❑ Construction | ❑ Daycare/childcare | ❑ Executive/legal | ❑ Food service industry |
| ❑ Health care | ❑ Heavy equipment operator | ❑ Heavy manual labor | ❑ Home services |
| ❑ Household | ❑ Light manual labor | ❑ Manufacturing | ❑ Medium manual labor |

**Recreational Activities:**

| | | | |
|---|---|---|---|
| ❑ Backpacking | ❑ Biking | ❑ Boating | ❑ Football |
| ❑ Golf | ❑ Racket Ball | ❑ Running | ❑ Skiing |
| ❑ Soccer | ❑ Swimming | ❑ Tennis | ❑ Walking |
| ❑ Weight Lifting | ❑ Other _____ | ❑ Other _____ | ❑ Other _____ |

**Have you had any recent falls, accidents, traumas or injuries of any kind?** ❑ Yes ❑ No

**If you selected "Y" please describe: _____**

***Review of Systems:***

**Have you had trouble with any of the following:**

| **Cardiovascular:** | Present | Past | No |
|---|---|---|---|
| Poor Circulation | | | |
| High Blood Pressure | | | |
| Aortic Aneurism | | | |
| Heart Disease | | | |
| Heart Attack | | | |
| Chest Pain | | | |
| High Cholesterol | | | |
| Pace Maker | | | |
| Jaw Pain | | | |
| Irregular Heartbeat | | | |
| Swelling of Legs | | | |

| **Genitourinary:** | Present | Past | No |
|---|---|---|---|
| Kidney Disease | | | |
| Lower Side Pain | | | |
| Burning Urination | | | |
| Frequent Urination | | | |
| Blood in urine | | | |
| Kidney Stone | | | |

| **Hematologic/lymphatic:** | Present | Past | No |
|---|---|---|---|
| Hepatitis | | | |
| Blood Clots | | | |
| Cancer | | | |
| Easy Bruising | | | |
| Easy Bleeding | | | |
| Fevers/Chills/Sweats | | | |

| **Neurologic:** | Present | Past | No |
|---|---|---|---|
| Stroke | | | |
| Seizures | | | |
| Head Injury | | | |
| Brain Aneurysm | | | |
| Numbness | | | |
| Severe Headaches | | | |
| Pinched Nerves | | | |
| Parkinson's Disease | | | |
| Carpal Tunnel | | | |
| Spinning/Balance | | | |

| **Respiratory:** | Present | Past | No |
|---|---|---|---|
| Asthma | | | |
| Tuberculosis | | | |
| Shortness of Breath | | | |
| Emphysema | | | |
| Cold/Flu | | | |
| Cough/Wheezing | | | |

| **Ears/Nose/Throat:** | Present | Past | No |
|---|---|---|---|
| Dizziness | | | |
| Hearing Loss | | | |
| Sinus Infection | | | |
| Nosebleed | | | |
| Sore Throat | | | |
| Difficulty Swallowing | | | |
| Bleeding Gums | | | |

| **Eyes:** | Present | Past | No |
|---|---|---|---|
| Glaucoma | | | |
| Double Vision | | | |
| Blurred Vision | | | |

| **Integumentary:** | Present | Past | No |
|---|---|---|---|
| Skin Ulcers | | | |
| Skin Disease | | | |
| Eczema | | | |
| Psoriasis | | | |
| Rashes | | | |

| **Psychiatric:** | Present | Past | No |
|---|---|---|---|
| Depression | | | |
| Anxiety Disorder | | | |
| Unusual Stress | | | |

| **Constitutional:** | Present | Past | No |
|---|---|---|---|
| Weight Loss/Gain | | | |
| Energy Level Problem | | | |
| Difficulty Sleeping | | | |

| **Allergic/Immunologic:** | Present | Past | No |
|---|---|---|---|
| Hives | | | |
| Immune Disorder | | | |
| HIV/AIDS | | | |
| Allergy Shots | | | |
| Cortisone Use | | | |

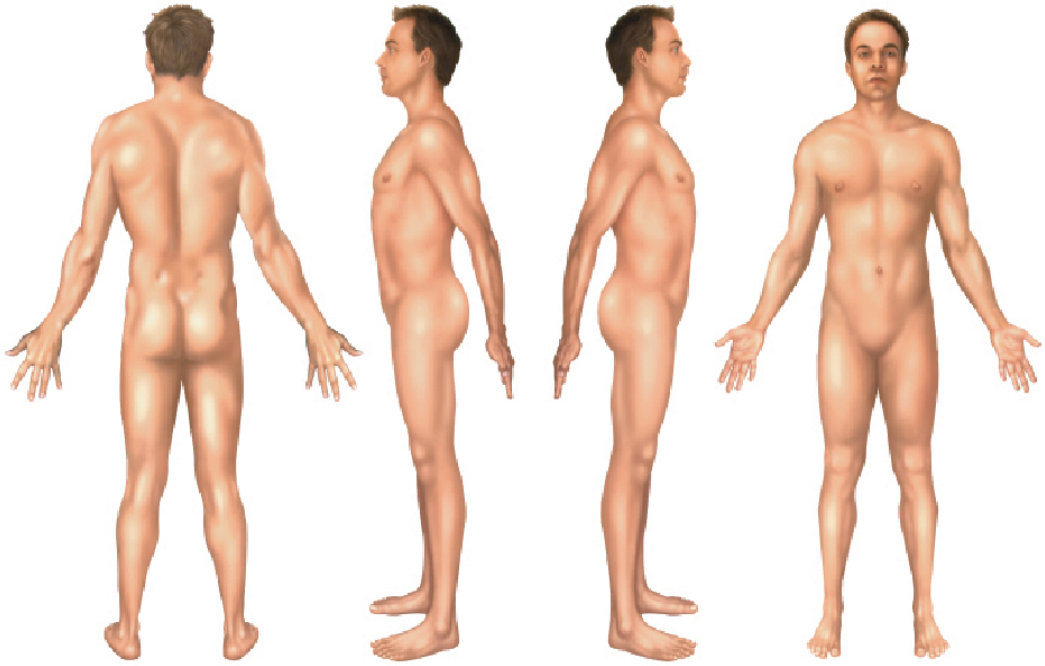
| **Gastrointestinal:** | Present | Past | No |
|---|---|---|---|
| Gallbladder Problems | | | |
| Bowel Problems | | | |
| Constipation | | | |
| Liver Problems | | | |
| Ulcers | | | |
| Diarrhea | | | |
| Nausea/Vomiting | | | |
| Bloody Stools | | | |
| Poor Appetite | | | |

| **Musculoskeletal:** | Present | Past | No |
|---|---|---|---|
| Gout | | | |
| Arthritis | | | |
| Joint Stiffness | | | |
| Muscle Weakness | | | |
| Osteoporosis | | | |
| Broken Bones | | | |
| Joints Replaced | | | |

| **Endocrine:** | Present | Past | No |
|---|---|---|---|
| Thyroid Disease | | | |
| Diabetes | | | |
| Hair Loss | | | |
| Menopausal | | | |
| Menstrual Problems | | | |

**By using the key below, indicate on the body diagram where you are experiencing the following symptoms:**

**# = Numbness** **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



**Describe your symptoms:**_____

_____

**When did your symptoms start? Month**_____ **Day**_____ **Year**_____

**How did your symptoms begin?**_____

_____

**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)

**What describes the nature of your symptoms?**

- ❑ Sharp
- ❑ Dull ache
- ❑ Numb
- ❑ Shooting
- ❑ Burning
- ❑ Tingling
- ❑ Stabbing

**How are your symptoms changing?**

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

**What makes your symptoms feel better?**

- ❑ Ice
- ❑ Heat
- ❑ Rest
- ❑ Massage/ rubbing
- ❑ Over the counters
- ❑ Medications
- ❑ Previous Chiropractic Care
- ❑ Other _____

**What makes your symptoms feel worse?**

- ❑ Standing
- ❑ Sitting
- ❑ Walking
- ❑ Activity
- ❑ Lifting
- ❑ Bending
- ❑ Twisting
- ❑ Other _____

**During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)**

- ❑ 0 None
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10 Unbearable

**During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):**

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit
❑ Extremely

**During the past 4 weeks, how much of the time has your condition interfered with your social activities?**

❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time
❑ None of the time

**In general, would you say your overall health right now is….**

❑ Excellent ❑ Very good ❑ Good ❑ Fair
❑ Poor

**Who have you seen for your symptoms:**

❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

**List the names of any other providers you have seen for this condition and the clinic name they are part of:**

❑
❑

**What treatment did you receive for your symptoms?**

❑ Adjustments ❑ Physical Therapy ❑ Medication ❑ Surgery
❑ Other

**When did you receive this treatment?**

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 – 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

**What tests have you had for your symptoms?**

❑ X-rays ❑ MRI ❑ CT Scan ❑ Other

**When were these tests done?**

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 - 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

**Have you had similar symptoms in the past?** ❑ Yes ❑ No

**If you have seen treatment in the past for the same or similar symptoms, who did you see?**

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

**List the names of any other providers you have seen for this condition and the clinic name they are part of:**

❑

**What is your occupation?**

❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

**If you are not retired, a homemaker or a student, what is your work status?**

❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other

**I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Dr. Garner will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Garner will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.**

**Signature:_____ Date: _____/_____/_____**

**Thank you. Please return to the front desk.**