PATIENT INFORMATION

Last Name:_____

First Name:_____

Address:_____

City:_____

State:_____ Zip Code:_____

Phone Number:_____

E-mail_____

Sex: M F Age:_____ D.O.B._____

Married Widowed Single

Separated Divorced Minor

Occupation:_____

PATIENT CONDITION

Reason for visit: _____

_____

When did symptoms begin?_____

Is pain condition getting progressively worse?

_____

Rate the severity of your pain on a scale from 1(least pain) to 10 (worst):_____

Type of pain: throbbing burning dull

tingling numbness aching sharp

shooting stiffness swelling cramping

Other:_____

How often do you experience pain?_____

_____

Movements that aggravate pain:

sitting standing walking bending

lying down twisting exercise driving

Health History

What treatment have you already received for your condition?

Chiropractic Medications Physical Therapy Surgery None

Other: _____

Name of doctor(s) who have treated your condition:

_____

Have you received any of the following? MRI CT-scan X-ray

(If so please bring any reports, discs or films to your next appointment)

Please check yes/no to indicate if you have had any of the following:

AIDS/HIV	yes	no	Liver Disease	yes	no
Alcoholism	yes	no	Measles	yes	no
Allergy Shots	yes	no	Migraines	yes	no
Anemia	yes	no	Miscarriage	yes	no
Appendicitis	yes	no	Multiple Sclerosis	yes	no
Arthritis	yes	no	Mumps	yes	no
Asthma	yes	no	Osteoporosis	yes	no
Bleeding Disorders	yes	no	Pacemaker	yes	no
Breast Lump	yes	no	Parkinson's	yes	no
Bronchitis	yes	no	Pinched Nerve	yes	no
Bulimia	yes	no	Pneumonia	yes	no
Cancer	yes	no	Polio	yes	no
Cataracts	yes	no	Prosthesis	yes	no
Chemical Dependency	yes	no	Psychiatric care	yes	no
Diabetes	yes	no	Rheumatic Fever	yes	no
Emphysema	yes	no	Scarlet Fever	yes	no
Epilepsy	yes	no	STD	yes	no
Fractures	yes	no	Suicide attempt	yes	no
Goiter	yes	no	Stroke	yes	no
Gout	yes	no	Thyroid Problems	yes	no
Heart Disease	yes	no	Tonsillitis	yes	no
Hepatitis	yes	no	Tuberculosis	yes	no
Hernia	yes	no	Tumors/Growths	yes	no
Herniated Disc	yes	no	Typhoid Fever	yes	no
Herpes	yes	no	Ulcers	yes	no
High B.P.	yes	no	Vaginal Infections	yes	no
High Cholesterol	yes	no	Whooping Cough	yes	no
Kidney Disease	yes	no	Other: _____		
Are you pregnant?	yes	no	If so, due date: _____		

NAME:_____ D.O.B._____ DATE:_____

Previous Surgeries/Accidents

Falls: _____

_____

_____

Date of fall: _____

Surgery: _____

_____

_____

Date of surgery: _____

Accident: _____

_____

_____

Date of accident: _____

Is your current condition due to an accident? _____

Type of accident: Home Work Auto

To who have you made a report of your accident?

Auto Insurance Employer Workers Comp

Attorney If so, Attorney's name: _____

Other: _____

Medications (including OTC): _____

_____

_____

Allergies: _____

_____

_____

Vitamins/Herbs/Minerals: _____

_____

_____

Typical Exercise Level: None Moderate Daily Heavy

Typical Work Activity Level: Light Moderate Heavy

Habits:

Smoking : packs/day_____

Alcohol : drinks/week_____

Coffee/Caffeine : cups/day_____

High Stress Level : reason_____

Any other conditions, treatments or anything else you think the doctor should know about that was not covered previously or in depth in this form: _____

_____

_____

_____

_____

_____

EMERGENCY CONTACT INFORMATION

(if this is the same as your spouse or legal guardian write "spouse" or "guardian")

Name of person to contact in case of emergency:_____

Relationship to you: _____ Home Ph: (____)_____-_____ Cell Ph: (_____)_____-_____

NAME:_____ D.O.B._____ DATE:_____

HOW DID YOU HEAR ABOUT US?

□ A Friend, Family or Co-worker – What's Their Name? _____

□ Internet □ I Drive by the office □ Other:_____

BUILDING YOUR HEALTH TEAM

We would like to keep you primary care physician (PCP) informed of your health status. It is our policy to send a brief description of our initial exam and plan of care to your (PCP) following your initial visit. Do you consent to have this information sent to your PCP? Yes □ No

PCP's Name: _____ Office Ph: (____)_____-_____

Office Address: _____ City: _____ State: ___ Zip: _____

NEWSLETTER

In order to keep you up to date on the latest health related news and Joyce Family Chiropractic & Wellness events, we would like to send you a monthly newsletter. Please select one of the following:

Yes, please send me the newsletter E-mail: _____