Welcome to Quality of Life Chiropractic Clinic

1. Patient Information (Please Print)

Name: ______________________________________
First Last MI

Address: ____________________________________

____
City State Zip

DOB: ____/_____/______ Age: _____ Sex: ☐M ☐F

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

SSN: ____________ - ____________ - ___________

Occupation: ___________________ ☐Full Time

Employer: _____________________ ☐Part Time

Address: ____________________________________

Work Phone #: ______________________________

2. Phone Numbers/Contact Information

CELL PHONE NUMBER ________________________

EMAIL: ___________________________________

*this is used for appointment reminders and basic in-office communication. *Will not be shared

Preferred Method of Contact: ☐Cell ☐Work ☐Email

Emergency Contact

Name: ______________________________________

Relationship: ______________________

Cell Phone Number: _______________________

Work Phone Number: _______________________

Primary Care Physician: _____________________

PCP's Phone Number: ____________________

3a - Health Info Information

PLEASE LIST YOUR:

Height: ___________ Weight: __________

Race (optional): ______ Ethnicity (optional): __________

3b -Insurance ☐None

Insurance Company:____________________

****GIVE CARD and Driver's License TO FRONT DESK****

Subscriber:____________________DOB:___/___/___

Relationship: ☐Self ☐Spouse ☐Dependent

4. Accident Information

Is this condition due to an accident? ☐Yes ☐No

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

Attorney:________________ PH#:________________

5. Referral Source

How did You hear about Us?

____

Have You Seen A Chiropractor Before? ☐ Yes ☐ No

When? ____________

6. Social History

	Daily	Weekly	Occasionally	None	How Much?
1. Alcohol Use	☐	☐	☐	☐	________________________
2. Coffee Use	☐	☐	☐	☐	________________________
3. Tobacco Use	☐	☐	☐	☐	________________________
4. Exercise	☐	☐	☐	☐	________________________
5. Pain Relievers	☐	☐	☐	☐	________________________
6. Soft Drinks	☐	☐	☐	☐	________________________
7. Water Intake	☐	☐	☐	☐	________________________
8. Hobbies	__________________________				

7. Female Only

Are you pregnant? ☐Yes ☐No

Are you trying to conceive? ☐Yes ☐No

Are you Nursing? ☐Yes ☐No

Are you taking Birth Control? ☐Yes ☐No

Do you experience painful periods? ☐Yes ☐No

Do you have irregular cycles? ☐Yes ☐No

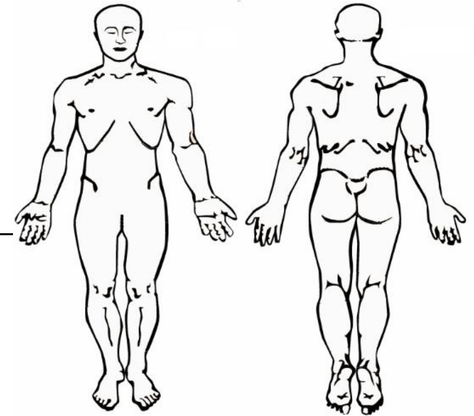
Menopause? ☐Yes ☐No

Last Menstrual Cycle:___________

8. Patient Condition – Your Main Complaint

1. Reason for Today's Visit: ____________________ Date Started ___/___/___
2. What is the Cause of your Pain/Discomfort? ____________________
3. Pain Scale (Circle One): Mild 0 1 2 3 4 5 6 7 8 9 10 Severe
4. Is Condition: ☐ Mild ☐ Moderate ☐ Severe
5. Quality of Symptoms? ☐ Aching ☐ Annoying ☐ Burning ☐Deep ☐Diffuse ☐Dull ☐Heavy ☐Intolerable ☐Pulling ☐Sharp ☐"Shock Like" ☐Stabbing ☐Stiffness ☐Throbbing ☐Tightness ☐Tingling ☐Other______________
6. How often do you feel this pain/discomfort?
   ☐Constant ☐Frequent ☐Intermittent ☐On & Off ☐Random ☐Recurring
7. Radiation – Does it affect other areas of your Body?: ____________________
8. What Makes It Better? ☐Chiropractic ☐Ice ☐Heat ☐Medication ☐Massage ☐Rest ☐Sitting ☐Standing ☐Stretching ☐Nothing
9. What Makes It Worse? ☐Chiropractic ☐Ice ☐Heat ☐Medication ☐Massage ☐Rest ☐Sitting ☐Standing ☐Stretching ☐Nothing ☐Bathing ☐Bending ☐Carrying ☐climbing Stairs ☐Computer Use ☐ Coughing or Sneezing ☐Driving ☐Lifting ☐Pushing ☐Pulling ☐Running ☐Walking ☐Other: ______________________________

10. Location (where does it hurt?)
Place on Illustration your condition:
"O" current "X" Past



11. What have you tried? ☐Prescription Medication ☐Over-the-counter drugs ☐Homeopathic Remedies ☐Physical Therapy ☐Surgery ☐Acupuncture ☐Chiropractic ☐Massage ☐Ice ☐Heat ☐Other:__________________

12. Does it Interfere With? ☐Bending Over ☐Caring for Family ☐Climbing Stairs ☐Concentrating ☐Dressing Myself ☐Driving a Car ☐Exercising ☐Getting in/out of Car ☐Getting to Sleep ☐Grocery Shopping ☐Household Chores ☐Lifting objects ☐Looking over shoulder ☐Love Life ☐Lying Down ☐Reaching Overhead ☐Showering or Bathing ☐Rising out of Chair ☐Sitting ☐Standing ☐Staying Asleep ☐Using a Computer ☐Walking ☐ Yard Work
    A. For How Long? ____________________________

9. Past Personal History

A. Illnesses

Had	Have	
☐	☐	Aids
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Arteriosclerosis
☐	☐	Cancer
☐	☐	Chicken Pox
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart Disease
☐	☐	Hepatitis
☐	☐	HIV Positive
☐	☐	Malaria
☐	☐	Measles
☐	☐	MultipleSclerosis
☐	☐	Mumps
☐	☐	Polio
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sexually Transmitted Disease
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Typhoid Fever
☐	☐	Ulcer
☐	☐	Other: ______________

B. Allergies

Are you allergic to any medications, foods, etc? ☐Yes ☐No If yes, please list: ____________
____

C. ACCIDENTS -car/fall/broken/sprain & YEAR

____
____
____
____

D. **Operations – Surgical interventions, which may or may not have included** hospitalization.

☐ Appendix Removal ☐Cancer
☐Bypass Surgery ☐Eye Surgery
☐Cosmetic Surgery ☐Hysterectomy
☐Pacemaker ☐Vasectomy
☐Elective Surgery: ______________________
☐Spine:________
☐Tonsillectomy ☐Other:________________

E. Do you have any of the following:
(To Be Discussed with Doctor before Adjustment)

Articular Hypermobility Disease:	☐Yes ☐No
Severe Demineralization of Bone:	☐Yes ☐No
Benign Bone Tumor (Spine):	☐Yes ☐No
Anti-Coagulant Therapy (Blood Thinner):	☐Yes ☐No
Radiculopathy with Progressive Neurological Signs:	☐Yes ☐No
Rheumatoid Arthritis:	☐Yes ☐No
Ankylosing Spondylitis:	☐Yes ☐No
Fracture(s):____________________	☐Yes ☐No
Dislocation(s):__________________	☐Yes ☐No
Unstable Os Odontoedeum (Upper Neck Injury)	☐Yes ☐No
Malignancies that involve- the Vertebral Column	☐Yes ☐No
Myelopathy	☐Yes ☐No
Cauda Equina Syndrome	☐Yes ☐No
Vertebrobasilar Insufficiency Syndrome	☐Yes ☐No
T.I.A/Stroke/Aneurysm	☐Yes ☐No

F. Medications (over the counter/prescribed) you are currently taking:

☐High Blood Pressure _________________ ☐Cholesterol ______________________
☐Pain/Muscle Relaxer_________________ ☐Arthritis__________________________
☐Depression_________________ ☐Anxiety_____________ ☐ADD/ADHD__________
☐Insulin______________ ☐Other____

G. Supplements You Are Currently Taking (Explain What They Are Treating or Preventing)

____
____

10. Medical History – Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check any condition that you've **Had** or currently **Have**.

Musculoskeletal:	Had	Have	**Neurological**:	Had	Have	**Digestive**:	Had	Have
Osteoporosis	☐	☐	Anxiety	☐	☐	Anorexia	☐	☐
Arthritis	☐	☐	Depression	☐	☐	Bulimia	☐	☐
Scoliosis	☐	☐	Headache	☐	☐	Ulcer	☐	☐
Neck Pain	☐	☐	Dizziness	☐	☐	Food Sensitivities	☐	☐
Back Problems	☐	☐	Pins & Needles	☐	☐	Heartburn	☐	☐
Hip Disorders	☐	☐	Numbness	☐	☐	Constipation	☐	☐
Knee Injuries	☐	☐	None	☐		Diarrhea	☐	☐
Foot/Ankle Pain	☐	☐	**Respiratory**:	Had	Have	None	☐	
Shoulder Problems	☐	☐	Asthma	☐	☐	**Sensory**:	Had	Have
Elbow/Wrist pain	☐	☐	Apnea	☐	☐	Blurred Vision	☐	☐
TMJ Issues	☐	☐	Emphysema	☐	☐	Ringing in Ears	☐	☐
Poor Posture	☐	☐	Hay Fever	☐	☐	Hearing Loss	☐	☐
None	☐		Shortness-			Chronic Ear Infection	☐	☐
Cardiovascular:	Had	Have	of Breath	☐	☐	Loss of Smell	☐	☐
High Blood-	☐	☐	Pneumonia	☐	☐	Loss of Taste	☐	☐
Pressure			None	☐		None	☐	
Low Blood-	☐	☐	**Endocrine**:	Had	Have	**Genitourinary**:	Had	Have
Pressure			Thyroid issues	☐	☐	Kidney Stones	☐	☐
High Cholesterol	☐	☐	Immune-			Infertility	☐	☐
Poor Circulation	☐	☐	Disorders	☐	☐	Bedwetting	☐	☐
Angina	☐	☐	Hypoglycemia	☐	☐	Prostate Issues	☐	☐
Excessive Bruising	☐	☐	Frequent-			Erectile Dysfunction	☐	☐
None	☐		Infection	☐	☐	PMS Symptoms	☐	☐
Skin:	Had	Have	Swollen Glands	☐	☐	None	☐	
Skin Cancer	☐	☐	Low Energy	☐	☐			
Psoriasis	☐	☐	**Constitutional:**	Had	Have	**Constitutional Cont.:**	Had	Have
Eczema	☐	☐	Fainting	☐	☐	Fatigue	☐	☐
Acne	☐	☐	Low Libido	☐	☐	Sudden Weight Gain	☐	☐
Hair Loss	☐	☐	Poor Appetite	☐	☐	Sudden Weight Loss	☐	☐
Rash	☐	☐	Weakness	☐	☐	None	☐	
None	☐							

11. Family History

Relative	**Age** (If Living)	**State of Health** Good	Poor	**Illnesses** (Stroke, Heart Attack, Cancer, Diabetes, Seizures Etc.)	**Age of Death**	**Cause of Death** Natural	Illness
Mother	_______	☐	☐	______________________	_______	☐	☐
Father	_______	☐	☐	______________________	_______	☐	☐
Sister 1	_______	☐	☐	______________________	_______	☐	☐
Sister 2	_______	☐	☐	______________________	_______	☐	☐
Brother 1	_______	☐	☐	______________________	_______	☐	☐
Brother 2	_______	☐	☐	______________________	_______	☐	☐
________	_______	☐	☐	______________________	_______	☐	☐
________	_______	☐	☐	______________________	_______	☐	☐

Are there any other hereditary health issues that you know about? ____

____

I have authorized the above information and certify it to be true and correct to the best of my knowledge, and hereby authorized this office of Chiropractic to provide me with Chiropractic care, in accordance with state statues.

Patient Signature ____ **Date** ______/______/________

I Have Reviewed Form (Doctor's Signature) ______________________________ Date______/______/_________