Bidwell CHIROPRACTIC

Patient's Name: ___________________________
Date: ___________________

What is the reason for your visit today? ____

Is *today's problem caused by:* □ Auto Accident □ Workman's Compensation □ Slip and Fall □ Other

Personal Information

Address ______________________________ City/State/Zip ___________________________

Phone # ________________ (home) ________________(cell)

E-mail___________________________ □ Check if you do not wish to receive newsletters

SS# ________________ Birth Date _____________ Age ______ Height ______ Weight ______

Marital status: Single Married Separated Divorced Widowed

Spouse's name (if applicable) ___________________________

Children's names and ages ____

Occupation _________________________ Employer ________________________________

Work Phone # _______________ Work Address _____________________________________

Is it okay to contact you at work? □ No □ Yes

Emergency contact: Name______________________ Relationship__________________

Phone #(s) ____

Primary Care Doctor (name, address, phone number) _______________________________
____

*How did you hear about our office?*____

Are you pregnant? □ No □ Yes If yes, how far along are you? ________________

Chiropractic History

*In your own words, what do you believe chiropractors do?*____________________________________

Have you ever seen a chiropractor before? □ No □ Yes If yes, how long ago? _____________
What was the name of the chiropractor? ________________ Did the treatment help? □ No □ Yes

Do any of your friends or relatives see chiropractors? □ No □ Yes
If yes, do they use chiropractic for □ Health maintenance/optimization □ Health problems □ Both

Are you seeking chiropractic for □ Health maintenance/optimization □ Health problems □ Both

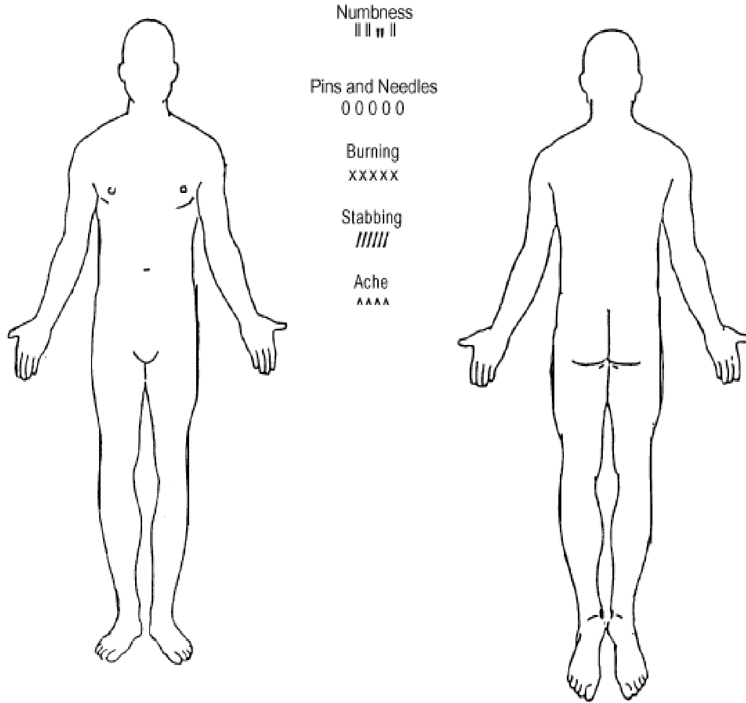
What do you hope to achieve with chiropractic care? ____

Chief Complaint

On the scale below, rate the pain intensity by circling the appropriate number. **0 = no pain, 10 = unbearable pain**

0	1	2	3	4	5	6	7	8	9	10

Indicate on the drawings below where you have pain/symptoms



How often do you experience the 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)

Comments: ____________________________

____

____

____

How would you describe the type of pain?

□ Sharp □ Numb □ Achy □ Burning □ Sharp with motion
□ Dull □ Tingly □ Diffuse □ Shooting □ Shooting with motion
□ Stiff □ Electric like □ Stabbing with motion
□ Other:____________________

How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

How much has the problem interfered with your work?

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

How much has the problem interfered with your social activities?

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

How long have you had this problem? ____________

How do you think your problem began?

____

Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

Chief Complaint Continued

What activities make the pain worse? □ Always There □ Bending □ Bicycling □ Breathing Deeply □ Climbing Stairs □ Coughing □ Driving □ Going Down Stairs □ Golf □ Painting □ Picking up a Child □ Running □ Sitting □ Sleeping □ Sneezing □ Prolonged Standing □ Standing Up □ Under Stress □ Using a Telephone □ Playing Tennis □ Throwing a Ball □ Travel □ Turning Over in Bed □ Walking □ Weather Changes □ Working □ Working at a Computer □ Working Out □ Other ____

What activities reduce the pain? □ Chiropractic Adjustments □ Analgesic Cream □ Bending Forward □ Exercising □ Heat □ Ice □ Listening to Relaxation Tapes □ Lying Face Down □ Lying on Back □ Lying on Side □ Massage □ Muscle Relaxers □ NSAIDS □ Pilates □ Prescription Pain Meds □ Resting □ Standing □ Stretching □ Swimming □ T.E.N.S. unit □ Tylenol □ Walking □ Warm Bath □ Wearing Orthotics □Yoga □ Sitting □ Nothing □ Other ____

What concerns you the most about your problem; what does it prevent you from doing?
____

Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician
□ ER physician □ Orthopedist □ Physical Therapist □ Other:_____________ □ No one

Health

How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do on a regular basis?
□ Strenuous □ Moderate □ Light □ None

Activities

What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half the day	□ A little of the day

What activities do you do outside of work? ____

Family History

Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

Medical History

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	*Present*	*Past*	*Present*	*Past*	*Present*
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	For Females Only	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____________________________				

List all prescription medications you are currently taking:

____

List all of the over-the-counter medications and supplements you are currently taking:

____

List all surgical procedures you have had:

____

*List any diagnostic tests you've had (i.e. x-rays, MRI, etc.)*____

____

Have you ever been hospitalized? □ No □ Yes
If yes, why? ____

Have you had significant past trauma? □ No □ Yes
If yes, what? ____

Is there anything else you think I should know?____

Patient Signature____________________________ Date_____________________________