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** _____ □ Do not wish to receive newsletters

SS# _____ Birth Date _____ Age _____

Height _____ Weight _____ ***Blood Pressure*** _____ □ Male □ Female

***Race:*** □ I - American Indian or Alaskan Native □ A - Asian □ B - Black or African American

□ P - Native Hawaiian or Pacific Islander □ W - White □ E - Other □ 7 - Declined

***Ethnicity:*** □ H - Hispanic or Latino □ N - Not Hispanic or Latino □ 7 - Declined

Preferred Language: _____

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? □ Yes □ No □ Mixed □ Other: _____

*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?*

_____

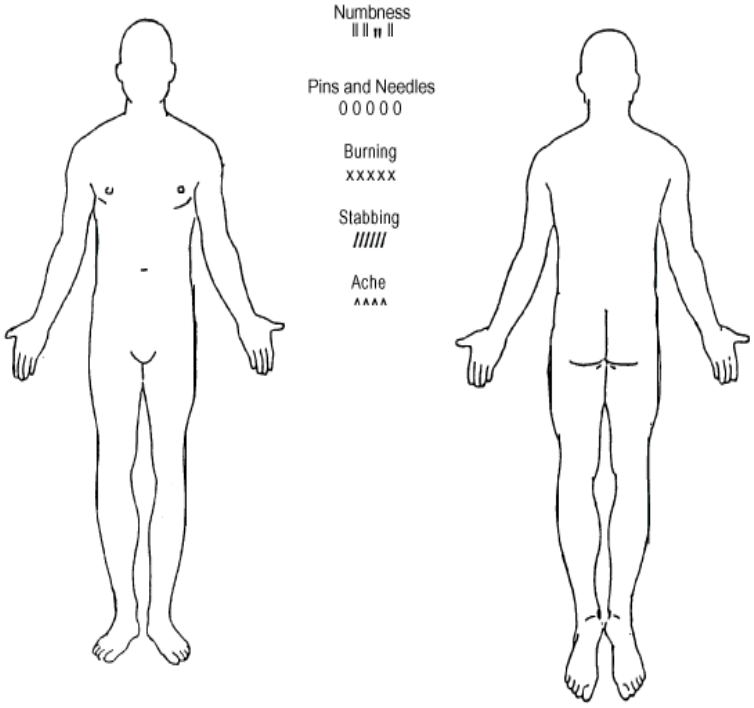
## *Chief Complaint*

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:

_____

## *Chief Complaint Continued*

*How would you describe the type of pain?*

□ Achy □ Burning □ Diffuse □ Dull □ Electric-like
□ Numb □ Sharp □ Shooting □ Stiff □ Tingly
□ Sharp with motion □ Shooting with motion □ 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

*What activities make the pain worse?*

□ Always There □ Bending □ Bicycling □ Breathing Deeply □ Climbing Stairs □ Coughing □ Driving □ Going Down Stairs □ Golf □ Lifting □ Painting □ Picking up a Child □ Playing Tennis □ Prolonged Standing □ Running □ Sitting □ Sleeping □ Sneezing □ Standing Up □ Throwing a Ball □ Travel □ Turning Over in Bed □ Under Stress □ Using a Telephone □ 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 □ Sitting □ Standing □ Stretching □ Swimming □ T.E.N.S. unit □ Tylenol □ Walking □ Warm Bath □ Wearing Orthotics □ Yoga □ 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: _____

## 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 |
| □ Drives: | □ Most of the day | □ Half the day | □ A little of the day |
| □ Manual Labor: | □ Most of the day | □ Half the day | □ A little of the day |

□ Other: _____

*What activities do you do outside of work?*
□ Nothing □ Aerobics □ Bike □ Golf □ Hike □ Jog □ Lift Weights □ Martial Arts □ Play Baseball
□ Play Basketball □ Play Soccer □ Play Tennis □ Play Volleyball □ Skate □ Swim □ Walk
□ Work Out □ Yoga □ Other: _____

## Family

*Indicate if you have any immediate family members with any of the following:*

| | | |
|---|---|---|
| □ Rheumatoid Arthritis | □ Diabetes | □ Lupus |
| □ Heart Problems | □ Cancer | □ ALS |

*What is their relation to you?*

_____

## Medical History

Smoking Status (*please circle*):

| | | | | | |
|---|---|---|---|---|---|
| Never Smoked | Former Smoker | Current Every Day Smoker | Current Some Day Smoker | Light Tobacco Smoker | Heavy Tobacco Smoker |

## *Medical History Continued*

*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 Change | □ | □ Dizziness |
| □ | □ Ankle/Foot Pain | □ | □ Loss of Appetite | □ | □ Chronic Sinusitis |
| □ | □ Jaw Pain | □ | □ Abdominal Pain | | |
| □ | □ Joint Pain/Stiffness | □ | □ Ulcer | | *Females Only:* |
| □ | □ Arthritis | □ | □ Hepatitis | □ | □ Birth Control Pills |
| □ | □ Rheumatoid Arthritis | □ | □ Visual Disturbances | □ | □ Hormonal Replacement |
| □ | □ Cancer | □ | □ General Fatigue | □ | □ Birth Control Pills |
| □ | □ Tumor | □ | □ Muscular Incoordination | □ | □ Pregnancy |
| □ | □ Asthma | □ | □ Liver/Gallbladder Disorder | | |
| □ | □ Other: _____ | | | | |

List all prescription medications you are currently taking:
*Check here if you are not currently taking any medications:* □

| **Medication:** *i.e. Lipitor* | **# of MD Refills issued?** | **Quantity of Pills:** | **Strength:** *i.e. 10mg* | **Dose Form:** *i.e. Capsule* | **MD's Instruction:** *i.e. 1 per day* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Are you allergic to any medicines? Please list each drug on a new line:
*Check here if you do not have any medicinal allergies:* □

| ***Name of Drug**: i.e. penicillin* | ***Symptom**: i.e. headache* | ***Severity:** (Circle one)* |
|---|---|---|
| | | *Mild Moderate Severe* |
| | | *Mild Moderate Severe* |
| | | *Mild Moderate Severe* |

## *Medical History Continued*

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

_____

_____

List all surgical procedures you have had
*Check here if you have not had any surgical procedures:* □

_____

_____

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?

_____

Please pick 2 security questions and answer them:

1) What is your mother's maiden name? _____

2) What city were you born in? _____

3) What was the make and model of your first car? _____

4) What is your favorite movie? _____

Patient Signature: _____

Date: _____