

*My Family Chiropractor*  
**CONFIDENTIAL PATIENT INFORMATION**

**Before beginning, please inform the Front Desk if you are here due to an auto accident or work-related accident. Please print clearly.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ S.S.# \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex: M  F  Occupation \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Marital Status: S  M  D  W  How many children? \_\_\_\_\_ Age(s) of children \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

**PRIMARY COMPLAINT**

**CHIEF COMPLAINT:**

- Neck Pain
- Low Back Pain
- Leg Pain L/R
- Other \_\_\_\_\_

- Mid Back Pain
- Arm Pain L/R
- Headache

**MODE OF ONSET:**

- Overexertion/Strenuous Position
- Gradual/Slow Onset
- Fall/Trip/Slip
- Other \_\_\_\_\_

**DATE OF ONSET:** \_\_\_\_\_

**SEVERITY:**

- Mild (annoyance – no impairment)
- Slight (some mild impairment)
- Moderate (marked impairment)
- Severe (incapacitated/bed-ridden)

**DURATION:**

- Intermittent (0-25%)
- Occasional (25-50%)
- Other \_\_\_\_\_
- Frequent (50-75%)
- Constant (75-100%)

**IS THE CHIEF COMPLAINT:**

- Getting worse
- Staying the same
- Getting Better

**CHARACTER:**

- Dull Ache
- Burning
- Other \_\_\_\_\_
- Sharp/Stabbing
- Throbbing

**RELATION TO OTHER BODY SYSTEMS:**

- Bowel/Bladder
- Muscle weakness
- Other \_\_\_\_\_
- Numbness/Tingling
- No apparent relationship

**RELIEVING FACTORS:**

- Rest/Exercise
- Bracing/Taping
- Other \_\_\_\_\_
- Sitting/Standing/Lying
- Hot/Cold Packs

**AGGRAVATING FACTORS:**

- Cough/Sneeze/Bowel Mvmt
- Driving/Riding/Sitting
- Changing body positions
- Other \_\_\_\_\_
- Lifting/Bending/Push/Pull
- Walking/Running/Standing

**DOES YOUR PROBLEM INTERFERE WITH:**

- Work
- Regular Activities
- Recreation
- Other \_\_\_\_\_
- Sleep
- Exercise

**MEDICATIONS:**  Aspirin  Ibuprofen  Acetaminophen How many daily? \_\_\_\_\_ Dosage? \_\_\_\_\_

Other \_\_\_\_\_

**WHEN WAS THE LAST TIME YOU REALLY FELT GOOD?** \_\_\_\_\_

## CURRENT HEALTH INFORMATION

PLEASE CHECK THE APPROPRIATE BOX FOR ANY OF THE FOLLOWING THAT APPLY NOW OR APPLIED IN THE PAST:

	N-Never	O-Occasionally	F-Frequently	C-Constantly		
<b>N O F C</b>	<b>N O F C</b>	<b>N O F C</b>	<b>N O F C</b>		<b>FAMILY HISTORY</b>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ringing Ears	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stomach Problems	Check any that apply:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Earaches/Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hot Flashes	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sore Throats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers	<input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Migraines	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> Cancer
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neck Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bed Wetting	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Middle Back Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Freq. Urination	<input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney Infection	_____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tingling/Sciatica	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bladder Infection	_____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hip Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heart Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Prostate Problems	_____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gall Bladder Problems	_____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fatigue	_____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Leg Pain/Cramps	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Strokes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Smoking	_____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Exercise	_____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Loss of Energy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep Difficulties	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eat Healthy	_____

## PAST HEALTH INFORMATION

**PREVIOUS SURGERIES (Please list all types):**

1. Type \_\_\_\_\_ Date \_\_\_\_\_
2. Type \_\_\_\_\_ Date \_\_\_\_\_
3. Type \_\_\_\_\_ Date \_\_\_\_\_

**PREVIOUS ACCIDENTS OR INJURIES (INCLUDING CHILDHOOD, ADOLESCENT, YOUNG ADULT, ADULTHOOD):**

1. Type \_\_\_\_\_ Date \_\_\_\_\_
2. Type \_\_\_\_\_ Date \_\_\_\_\_
3. Type \_\_\_\_\_ Date \_\_\_\_\_

*My Family Chiropractor*  
**INSURANCE INFORMATION**

- We need your Insurance Cards so we may make a photocopy for your file.
- We will contact your insurance carrier and let you know about your chiropractic coverage.

**PAYMENT POLICIES**

We offer direct billing for personal injury, authorized worker's compensation, private insurance/group health, and Medicare claims. We also offer prompt payment discounts for patients who pay at the time of service and remit their own insurance claim forms. We will provide claim forms and any necessary reports to help you receive reimbursement from your insurance company. If you do not have insurance, or your insurance coverage is limited, we accept cash, personal checks, or VISA and MasterCard.

**TO HELP US BETTER EXPLAIN YOUR CHIROPRACTIC CONDITION AND HOW WE MAY BE ABLE**

**TO HELP YOU, PLEASE CHECK THE BEST ANSWER:**

I remember important things in my life by:

- What I see.
- What I feel.
- What I hear.

The primary reason I brush my teeth is to:

- Avoid tooth decay and gum disease.
- Make sure I have healthy teeth & gums.

**When I make decisions I generally:**

- Gather facts and weigh the evidence
- Make the right choice instantly
- Consult my friends and family
- Depend upon how I "feel" about it

**Please share with us two things you've heard about chiropractic, especially if it is a personal concern.**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**List two activities your condition prevents you from participating in.**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**What do you hope to do better or enjoy more when you regain your health?**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**What are your expectations of today's visit?** \_\_\_\_\_

**READ & SIGN BELOW**

I understand that My Family Chiropractor, by means of a chiropractic adjustment, corrects or reduces nerve interferences (subluxations). Thus, the normal nerve function restores itself. The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency. I further understand that My Family Chiropractor does not diagnose, treat, or claim to cure disease.

Date \_\_\_\_\_ Signature \_\_\_\_\_ Print Name \_\_\_\_\_

# MY FAMILY CHIROPRACTOR CONFIDENTIAL QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Directions:** Circle the appropriate answer. If you don't know, circle both. If you need to; PLEASE write comments.

<p>Do you get pain or discomfort when you bite?</p>	YES	NO	<p>Does pressure or pain in the head often make life miserable?</p>	YES	NO
<p>Do you have problems with your speech?</p>	YES	NO	<p>Have you ever fainted?</p>	YES	NO
<p>Does it hurt, or is it difficult to swallow?</p>	YES	NO	<p>Do you have thyroid trouble?</p>	YES	NO
<p>Does it hurt to shrug your shoulders?</p>	YES	NO	<p>Is illness common in your family?</p>	YES	NO
<p>Do you have trouble with normal tongue movement?</p>	YES	NO	<p>Do you have numbness or tingling in any part of your body?</p>	YES	NO
<p>Do you get pain that wakes you up from sleep?</p>	YES	NO	<p>Were you ever knocked unconscious?</p>	YES	NO
<p>Do you ever notice blindspots?</p>	YES	NO	<p>Have you had a twitching of the face, head or shoulders?</p>	YES	NO
<p>Do you ever have any abnormal bleeding (nose, ears, mouth, stool, urine)?</p>	YES	NO	<p>Have you or someone in your family ever had convulsions (or epilepsy) Who?_____</p>	YES	NO
<p>Have you ever been in a coma?</p>	YES	NO	<p>Are you or were you a bedwetter? To what age?_____</p>	YES	NO
<p>Have you ever had a stroke?</p>	YES	NO	<p>Have you had tests that indicate the possibility of a venereal disease?</p>	YES	NO
<p>Have you suffered frequent cramps in your legs?</p>	YES	NO	<p>Have you ever had a tumor or cancer?</p>	YES	NO
<p>Has a doctor ever said you have heart trouble?</p>	YES	NO	<p>Do you often have small accidents or injuries?</p>	YES	NO
<p>Do you often eat sweets between meals?</p>	YES	NO	<p>Did you ever have a serious injury?</p>	YES	NO
<p>Has a doctor ever said you have ulcers?</p>	YES	NO	<p>Are you often ill?</p>	YES	NO

Have you ever been told you have osteoporosis?	YES	NO	Have you been told you have arthritis?	YES	NO
Do you often have a loss of memory?	YES	NO	Do you have hearing trouble?	YES	NO
Do you have shortness of breath?	YES	NO	Do you have chest pains?	YES	NO
Do you frequently have trouble sleeping?	YES	NO	Do you have varicose veins?	YES	NO
Do you get menstrual cramps, constipation, or hemorrhoids? (Circle all that apply)	YES	NO	Do your ankles swell easily?	YES	NO
Have you ever had T.B.?	YES	NO	Have you ever had diabetes?	YES	NO
Have you ever been diagnosed as hypoglycemic?	YES	NO	Do you know that the power that made the body can heal the body?	YES	NO
Do you know that each cell receives its information for life from the brain; and that interference will cause a malfunction?	YES	NO	Do you know that chiropractic works toward locating and removing interference between the brain and body?	YES	NO
Do you know that we correct the cause, rather than the symptoms?	YES	NO	Are you ready to be helped?	YES	NO

**"THE DOCTOR OF THE FUTURE WILL GIVE NO MEDICATIONS BUT WILL INTEREST HIS PATIENTS IN THE CARE OF THE HUMAN FRAME, IN DIET AND IN THE CAUSE AND PREVENTION OF DISEASE."**

**YOU'VE COME TO THE RIGHT PLACE!**