

# PATIENT ENTRANCE INFORMATION

Name: \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

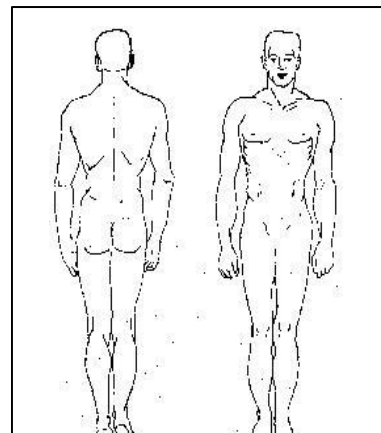
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Marital Status: S M D Number of Children: \_\_\_\_\_

Who Referred You to Our Office: \_\_\_\_\_

Emergency Contact Name and #: \_\_\_\_\_

Is today's visit related to an auto or work related accident: Y N  
If yes, when: \_\_\_\_\_



Circle the Area(s) that Bother You

## *CASE HISTORY*

Have you received Chiropractic care before: Y N  
If yes, for what and when was your last visit: \_\_\_\_\_

Chief Complaint: 1. \_\_\_\_\_

Other Complaints: 2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Complaint started on: \_\_\_\_\_ How did your problem begin: \_\_\_\_\_

What makes your condition worse: \_\_\_\_\_

What makes your condition better: \_\_\_\_\_

Quality of symptoms: Dull Ache Sharp Shooting Burning Throbbing Deep Stinging Numb/Tingle/Pins & Needles

Does your condition radiate/travel to another part of your body: Y N Where: \_\_\_\_\_

Severity of your symptoms:	<i>No Symptoms</i>				<i>Moderate</i>				<i>Excruciating Symptoms</i>			
On average:	0	1	2	3	4	5	6	7	8	9	10	
At Best:	0	1	2	3	4	5	6	7	8	9	10	
At Worst:	0	1	2	3	4	5	6	7	8	9	10	

Symptoms are: Occasional Intermittent Frequent Constant How long do they last: \_\_\_\_\_

What time of day are your symptoms worse?: Morning Midday Late Afternoon Evening All Day

Other treatments for this condition: \_\_\_\_\_

Have you had any past injuries, fractures, surgeries or illnesses that may have contributed to your condition: Y N

If yes, describe: \_\_\_\_\_

Are you left or right dominant: L R Are you pregnant: Y N

Other conditions that you commonly experience or have had in the last 6 months:

Headaches  Sleeping Problems  Back Pain  Neck Pain  Leg Pain  Balance Issues  
 Cholesterol  Asthma  Fatigue  Depression  Diarrhea  Stomach Upset  
 Loss of Memory  High Blood Pressure  Chest Pain  Asthma  Ears Ring  Frequent Colds  
 Numbness  Cold Hands/Feet  Joint Pain  Arthritis  Allergies  Arm/hand Pain  
 Eating Disorder  Menstrual Cramps  Heart Issues  Weight Loss  Dizziness  Painful Urination  
 Sinus Trouble  Irritable Colon  Osteoporosis  Fainting  Constipation  Thyroid Disorder

What does your condition prevent you from doing: \_\_\_\_\_

Medications and reasons for taking: \_\_\_\_\_

Vitamins/supplements taking regularly: \_\_\_\_\_

Rate your diet: Poor Fair Good Excellent

Exercise frequency: None/Rare 1-2X/week 3-4X/week 4-5X/week 6-7X/week

Describe regular exercise/activities you do: \_\_\_\_\_

Surgeries and dates: \_\_\_\_\_

Allergies: \_\_\_\_\_ Smoking habits: Y N If yes, how much \_\_\_\_\_

Past Health History/Family History ("P" for patient and "F" for family member that is a blood relative):

Abdominal pain  Bulemia  Fainting  Kidney Stones  Rapid Heart Rate  Ulcer  
 Allergies  Cancer  Heart Attack  Liver Disease  Tuberculosis  Fractures  
 Anorexia  Convulsions  High Cholesterol  Low Blood Pressure  Scoliosis  Gallstones  
 Arthritis  Dislocations  Lung disease  Multiple Sclerosis  Sickle Cell Anemia  Diabetes  
 Asthma  Dizziness  High Blood Pressure  Osteoporosis  Disc Conditions  
 Blood Disorders  Emphysema  Irritable Bowel  Frequent Urination  Stroke  
 Breast Condition  Epilepsy  Kidney Disease  Prostate Disease  Thyroid Disorder

I have read the above information and certify it to be true and accurate to the best of my knowledge. I hereby authorize the Doctor to provide me with evaluation and treatment of my condition in accordance with Georgia's statutes.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_