Farmville Family Chiropractic Confidential Patient Information

Name:____Date:_________________________

Address:____________________________City:__________________State:__________Zip:________

Date of Birth:__________________ Age:______ Gender: ☐ Male ☐ Female, Marital Status: ☐ M ☐ D ☐ W ☐ S

Home Phone:____________________________________ Cell Phone:_______________________

Email: ____ Social Security #:__________________

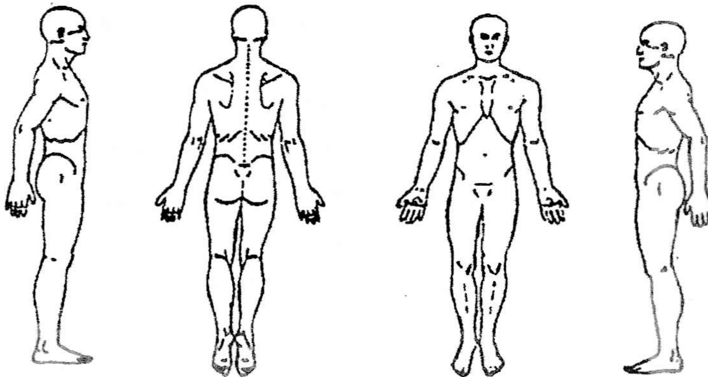
Employer:____Phone:___________________

Occupation:____________________________________ Spouse Name:_____________________

How did you hear about us?____________________Name of Person who referred you?_______________

In the space below, please describe your major complaint:

Please mark the exact location of your pain on the diagram below:



Description

☐ Sharp

☐ Dull

☐ Ache

☐ Weak

☐ Throbbing

☐ Numb

☐ Shooting

☐ Burning

☐ Tingling

Frequency

☐ Constant(76-100%)

☐Frequent(51-75%)

☐Occasional(26-50%)

☐Intermittent (25% or less)

Intensity

No Pain Severe Pain

1 2 3 4 5 6 7 8 9 10

Have your symptoms:

☐Decreased ☐Not Changed ☐Increased

How did this condition develop? (How did it start?)____

____

When was the first time you were aware of this problem? _____________________________________

____

Have you ever had this problem or similar problem before? Please explain: _______________________

____

Have you ever received any treatment for this condition? If yes, by whom, where, when and what were the results?____

____

Has your work status changed because of this complaint? ☐ Yes ☐ No

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

Over →

If you have ever had a listed symptom the past, please check that symptom in the *past column*. If you are presently troubled by a symptom, please check that symptom in the *present column*. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Angina
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast ☐Soreness ☐Lumps
☐	☐	Cancer, Explain_____________
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/Irregular Bowels
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty Swallowing
☐	☐	Dizziness/Fainting
☐	☐	Emphysema
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Grinding/Popping sounds in neck
☐	☐	Hand Pain (☐ right ☐ left)
☐	☐	Heartburn/Indigestion
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Disorders
☐	☐	Kidney Stones
☐	☐	Liver/Gallbladder Problems

Past	Present	Condition
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Neck Pain
☐	☐	Pain in ankle or foot(☐ right ☐ left)
☐	☐	Pain in Lower Leg/Knee(☐right ☐left)
☐	☐	Pain in upper arm/elbow(☐right ☐left)
☐	☐	Pain in upper leg/hip (☐right ☐left)
☐	☐	Painful Urination
☐	☐	PMS
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain (☐ right ☐ left)
☐	☐	Stroke (date:_________________)
☐	☐	Swelling, Stiffness of Joints
☐	☐	Tinnitus (Ear Noises)
☐	☐	Tumor, Explain ___________________
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Other _________________________

Does a family member have any of the following?

☐ Cancer
☐ Rheumatoid Arthritis
☐ Diabetes
☐ Heart Problems
☐ Lung Problems
☐ High Blood Pressure
☐ Thyroid Disease/Goiter
☐ Chronic Back Pain
☐ Chronic Headaches
☐ Lupus
☐ Other_______________

Please check any of the following that apply to you:

☐ Pregnancy # births___
☐ Medications
☐ Hospitalizations/Surgeries
☐ Tobacco
☐ Alcohol
☐ Coffee/tea/soft drinks ______ cups/cans per day

____

Signature