FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

PRIMARY CARE FOLLOW-UP:
PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****
Patient Name: Last _____ First _____ Date _____ / _____ / _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____
Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____
Marital Status: S M D W Spouse's Name: _____ Referred by: _____
Person responsible for payment: _____ Patient Employed by: _____
Occupation: _____ Work Phone: (____) ____ - _____
Email: _____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email
Have you ever been to a Chiropractor before?: YES NO
Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation

CHIEF COMPLAINT: Answer the questions as completely as possible. If a question does not apply, leave it blank.

Reason for today's appointment (Annual physical, Lab work, Sick visit, etc): _____

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Occasionally (26-49%) ☐ Intermittently (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

Please add any other information about the primary complaint that may be helpful:
_____

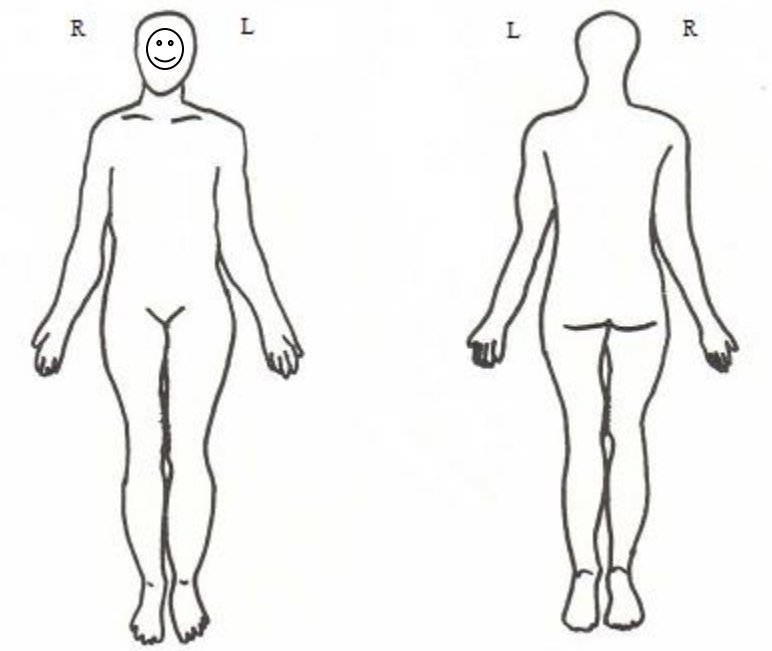
*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

KEY:	
Numbness / Tingling	**=======**
Pins & Needles	**oooooooo**
Burning pain	**xxxxxxxx**
Dull / achy pain	**……**
Sharp / Stabbing pain	**////////////////**



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain **Worst pain**

0 (1) 2 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

No Pain **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S INITIALS_____DATE_____

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE ☐.

ALLERGIC/IMMUNOLOGIC: ☐ NONE
Food Allergies Hay fever Frequent sinus problems Hives

CONSTITUTIONAL: ☐ NONE
Fainting Poor appetite Sudden weight gain Weakness Difficulty concentrating Dizzy spells Nervousness
Low libido Fatigue Sudden weight loss Chills Difficulty sleeping Fever Night sweats

ENDOCRINE: ☐ NONE
Hypothyroid Type I Diabetes (juvenile) Frequent infections Being tired a lot Changes in hair growth Excessive hunger
Extreme thinness General weakness Heat intolerance Eat to relieve fatigue Unexplained weight loss Hyperthyroid
Type II Diabetes Loss of appetite Unusually jumpy/nervous Cold intolerance Excessive Thirst
Drowsy after eating Shaky if hungry Hoarseness Unexplained weight gain

GASTROINTESTINAL: ☐ NONE
Anorexia/Bulimia Food Sensitivities Constipation Nausea Abdominal gas Acid reflux Black /tarry stools
Frequent indigestion Ulcer Heartburn Diarrhea Vomiting Abdominal pain Belching after meals
Difficulty swallowing

HEMATOLOGIC/LYMPHATIC: ☐ NONE
Jaundice Bleeding/bruising Swollen glands Leukemia Lymphoma Liver problems Anemia Blood clots Hemophilia Myeloma

MUSCULOSKELETAL: ☐ NONE
Osteoporosis Arthritis Back pain Joint pain Muscle weakness Frequent foot/leg cramps Heel spurs Joint stiffness
Scoliosis Neck pain TMJ pain Muscle pain Back injuries General muscle tension Hot joints Joint swelling

PSYCHIATRIC: ☐ NONE
Alcoholism Emotional stress Extreme worry Feeling miserable/blue Hallucinations Recurrent bad dreams
Being timid/shy Crying often Eating when nervous Feeling angered/ irritable Insecurity Phobias Sleep walking

CARDIOVASCULAR: ☐ NONE
High blood pressure High Cholesterol Poor Circulation Unusually slow heart rate Bleeding problems Blue extremities
Light-headed when standing Heart problems Low blood pressure Chest pain Ankle swelling Angina
Blood clots Cold hands/feet Heart murmur Leg pain walking short distances

EARS, NOSE &THROAT: ☐ NONE
Ear noises/ringing Chronic ear infection Loss of taste Blisters/Cold sores Deviated Septum Dysphagia
Ear pain Frequent colds Hearing loss Loss of smell Bleeding gums Dental Problems
Dry mouth Ear discharge Excessive saliva Gum disease

EYES: ☐ NONE
Blurred vision Injury Crossed Eyed Far Sightedness Glaucoma Near sightedness Swelling
Vision Headaches Burning sensation Cataracts Dry/Gritty Feeling heartbeat in eyes Itchy Redness
Tearing/crusting

GENITOURINARY: ☐ NONE
Kidney stones Prostate issues Infertility PMS symptoms Bladder control problems Foul smelling urine
Discolored urine Frequent urination Kidney/Bladder infections Bedwetting Erectile dysfunction Discharge
Burning Difficulty starting stream Dribbling Getting up at night to urinate

INTEGUMENTARY/SKIN: ☐ NONE
Skin cancer Eczema Hair loss Boils Coarse/bumpy skin Dandruff Excessive perspiration Itching Psoriasis
Acne Rashes Bruising Corns Dryness Hair changes Nail bed changes

NEUROLOGICAL: ☐ NONE
Anxiety Headaches Pins/needles Seizures Confusion Difficulty of Speech Epilepsy Forgetfulness
Depression Dizziness/Vertigo Numbness/Tingling Memory loss Convulsions Double vision Fainting spells Hand Trembling

RESPIRATORY: ☐ NONE
Coughing Asthma Emphysema COPD Chronic cough Coughing up blood Non-productive/dry cough
Shortness of breath Apnea Pneumonia Hay fever Asbestos exposure Congestion Difficulty breathing

PATIENT'S INITIALS_____DATE_____

SURGICAL HISTORY:

Please list any surgeries that you have had your LAST evaluation. Also INCLUDE RIGHT OR LEFT side of body where applicable.

- □ **I have NOT had any NEW surgeries since my LAST evaluation.**

PROCEDURE:	DATE:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Please list any allergies as well as your reaction to the allergen if known.

Enviromental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____