

Confidential Patient Data

Western Mountain Chiropractic and Sports Injury

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Social Security #: _____ Age: _____ Male Female

Marital Status: Married Single Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Spouse Occupation _____ Spouse Employer _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Mail Clinic Location Other _____

Who is your family Doctor: _____ Phone: _____

Are you covered by more than one insurance company? Yes No

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	spine surgery	<input type="checkbox"/>	Other _____		

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

Do you have a pacemaker/metallic implants? Yes No If female: Are you pregnant? Yes No

Have you had chiropractic treatment in the past? Yes No Date of Last Visit _____

Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How much? _____

Do you exercise? Yes No How often? _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

ACCIDENT HISTORY :

- Job Auto Other 1. _____ Date: _____
- Job Auto Other 2. _____ Date: _____
- Job Auto Other 3. _____ Date: _____

Are both of your parents still alive? Yes No (please explain cause(s) death below) example (heart attack):

Do you have children? None Boys; Ages _____ Girls; Ages _____

Please Describe Your Present Conditions:

Body Area _____ (example: low back, neck, headache)
Please Circle Best Responses From Each Line Below

Pain Level: 1 2 3 4 5 6 7 8 9 10 (1 is least, 10 is worst)
Mild - Mild to Moderate - Moderate - Moderately Severe - Severe
Constant - Occasional - Intermittent - Frequent

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Please Circle Best Responses From Each Line Below

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Please explain how you feel this injury/condition occurred: _____

Please Check All Activities That Are Worsened By Your Present Condition

General

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Chewing | <input type="checkbox"/> Getting In/Out of Vehicle | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting Children | <input type="checkbox"/> Reading | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Sexual Intercourse | <input type="checkbox"/> Running | <input type="checkbox"/> Bending | <input type="checkbox"/> Lying in Bed | <input type="checkbox"/> Using Computer |
| <input type="checkbox"/> Exercising | <input type="checkbox"/> Sitting in Recliner | <input type="checkbox"/> Walking | <input type="checkbox"/> riding in car | |

Housework

- | | | | | |
|---|--|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Doing Laundry | <input type="checkbox"/> Making Beds | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Washing Dishes | <input type="checkbox"/> Ironing |
| <input type="checkbox"/> Carrying Groceries | <input type="checkbox"/> Caring for Pets | <input type="checkbox"/> Cooking | <input type="checkbox"/> Sweeping | <input type="checkbox"/> Other _____ |

Yard Work

- | | | | | |
|--------------------------------------|--|------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Mowing Lawn | <input type="checkbox"/> Raking Leaves | <input type="checkbox"/> Gardening | <input type="checkbox"/> Cutting Wood | <input type="checkbox"/> Other _____ |
|--------------------------------------|--|------------------------------------|---------------------------------------|--------------------------------------|

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- COUGHING SNEEZING STRAINING AT STOOL BENDING CARRYING CLIMBING A LADDER
 CLIMBING STAIRS DRIVING EXERCISING GETTING OUT OF BED IN/OUT OF CAR LIFTING
 PULLING PUSHING REPETITIOUS MOVEMENTS STANDING STOOPING
 WALKING UPHILL WALKING HEAT COLD

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- CHIROPRACTIC CARE (ADJUSTMENTS) TAKING ADVIL TAKING ASPIRIN TAKING PAIN PILLS
 TAKING TYLENOL EXERCISING RECLINING RESTING SLEEPING WALKING COLD/ICEPACK
 MASSAGING BY HAND HEAT (HOT PACK) RUBBING HEAT LINIMENT
 HOT SHOWERS RUBBING MINERAL ICE TUB SOAKING

Patient's Signature: _____ Date: _____