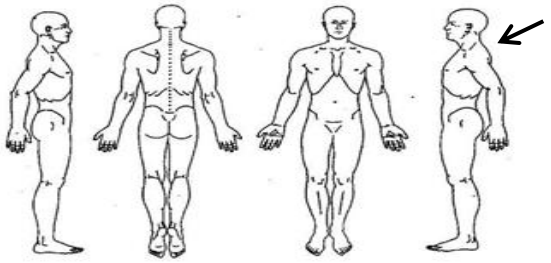
PATTERSON CHIROPRACTIC CENTER

Name (Last)_____ (First)_____ (Middle)_____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital S M D W Sex M F SS #_____ Spouse's Name _____

Home # (___) _____ Work # (___) _____ Cell # (___) _____ E Mail _____



Please outline and shade where you have pain or other symptoms

* **When did your symptoms start?** _____
* **How did your symptoms begin?** _____

_____

Have you had similar episodes in the past? Y / N

1. PRIMARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

***Please circle current pain level*:**

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

2. SECONDARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

3. ADDITIONAL conditions:

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
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What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

Have you seen another doctor for your <u>CURRENT</u> condition(s)? ___ No ___ Yes When_____

Have you had previous tests or studies for your <u>CURRENT</u> condition(s)? ___ No ___ Yes When_____

Have you had previous medications or care for your <u>CURRENT</u> condition(s)? ___ No ___ Yes When_____

Have you lost time from work due to this <u>CURRENT</u> problem? ___ No ___ Yes When_____

To your knowledge, are you pregnant? ___ No ___ Yes

Please indicate any changes since your last visit to our office.

New Medications:	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Surgeries/Hospitalized since last visit:	**Type/area**_____**Surgeon**_____**When?**_____
	Type/area_____**Surgeon**_____**When?**_____
	Type/area_____**Surgeon**_____**When?**_____
	Type/area_____**Surgeon**_____**When?**_____
Current Vitals:	**Height: _____ft. _____ inches Weight:**_____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me and charged to me are my responsibility to be paid to the doctor. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ **DATE** _____

GUARDIAN'S SIGNATURE _____ **DATE** _____