

Patient Information

Welcome to Crestwood Chiropractic! Please fill out the personal information below. If you need any assistance please inform the front desk. Bring your completed paperwork to the front desk. Thank you!

First Name _____ Middle _____ Last _____

Sex Male Female Date of Birth ____ / ____ / ____ Age ____

Address _____ City _____ State ____ Zip _____

Home Phone (____) _____ Cell (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: Home Cell Work No Preference

Social Security Number _____ Email Address _____

Single Married Divorced Widowed Partnered for ____ years

Spouse's Name _____

Name of person responsible for this account _____

Patient Employer/School _____ Occupation _____

Employer/School address _____

Employer Phone Number (____) _____

Person to contact in case of an emergency _____ Phone (____) _____

Family Physician _____ Phone (____) _____

What is your primary complaint? _____

Whom may we thank for referring you to us? _____

Patient Informed Consent

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____ Date _____

HEALTH HISTORY

Mark any of the following condition(s) that you have experienced:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | _____ |

Explain the condition(s) you experienced; include the date(s) they occurred:

Mark any surgeries you have had and the dates which they occurred:

- | | | |
|---|---|---------------------------------------|
| <u>Year of surgery:</u> | <u>Year of surgery:</u> | |
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Hernia _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Colon _____ | <input type="checkbox"/> Kidney _____ | _____ |
| <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Stomach _____ | _____ |
| <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Tonsils _____ | |
| Women: | Men: | |
| <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Prostate _____ | |
| <input type="checkbox"/> Uterus _____ | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Ovaries _____ | | |

What other major injuries have you had? Date: _____

Have you been hospitalized? Date: _____

Do you have a pacemaker? ___ No ___ Yes

Are you pregnant? ___ No ___ Yes

Mark any of the following that you have ever taken:

- | | |
|--|---|
| <u>Year:</u> | <u>Year:</u> |
| <input type="checkbox"/> Birth Control _____ | <input type="checkbox"/> Blood Pressure _____ |
| <input type="checkbox"/> Cortisone _____ | <input type="checkbox"/> Insulin _____ |
| <input type="checkbox"/> Male/Female Hormones _____ | <input type="checkbox"/> Thyroid Medicine _____ |
| <input type="checkbox"/> Tranquilizers/Sedatives _____ | <input type="checkbox"/> Cholesterol Medicine _____ |

List all medications you are currently taking:

Patient Signature _____ **Doctor Signature** _____

Date _____

HEALTH HISTORY continued

List all vitamins or nutritional supplements you currently take:

Mark any of the following condition(s) that you have experienced:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fever | <input type="checkbox"/> Lumps | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Headache | <input type="checkbox"/> Masses | <input type="checkbox"/> Soreness |
| <input type="checkbox"/> Concentration Loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Spinal Curvature |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Difficulty of Speech | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Tenderness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Loss of coordination | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Sensation | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weak Grip |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
| | | <input type="checkbox"/> Paralysis | |

Mark any of the following allergies that you have:

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Animal Dander | <input type="checkbox"/> Hay | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Latex | <input type="checkbox"/> Second Hand Smoke |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Grasses | <input type="checkbox"/> Perfumes | |

DAILY HABITS

Frequency of exercise:

___ Never ___ Rarely ___ Occasionally ___ Moderately ___ Regularly

Intensity of exercise:

___ Low level ___ Medium level ___ High level ___ Competition level

Hours of sleep:

___ Less than 10 hours ___ 10 or more hours

Do you smoke?

___ No ___ Occasionally ___ 1 to 2
___ 2 to 3 ___ 4 to 5 ___ More than 5 packs/day

Do you drink alcohol/liquor beverages?

___ No ___ Occasionally ___ 1 to 2
___ 2 to 3 ___ 4 to 5 ___ More than 5 drinks/day

Do you drink coffee or caffeinated beverages?

___ No ___ Occasionally ___ 1 to 2
___ 2 to 3 ___ 4 to 5 ___ More than 5 drinks/day

Patient Signature _____ Doctor Signature _____

Date _____

History of Pain/Complaint

Is this pain/complaint due to a work injury or automobile accident? No Yes

Describe your pain/complaint(s). Please include specific location of pain/symptom and date of onset:

What caused the onset? _____

Since your pain/complaint(s) began, have you done anything to make your pain/complaints worse? No Yes

If YES, please explain: _____

Please describe the character of your current symptoms (You may check **more than one** answer):

- | | | | | |
|-----------------------------------|------------------------------------|---|--|----------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Sore/Ache | <input type="checkbox"/> Sharp | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Numbness | <input type="checkbox"/> Shooting/Radiating | <input type="checkbox"/> Weakness | |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Spasm | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Restricted Movement | |

Indicate the intensity of your pain/symptoms on their average: (Check **ONE** number)

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Pain/Symptoms are **better** in: Morning Afternoon Evening No Change with Time of Day

Pain/Symptoms are **worse** in: Morning Afternoon Evening No Change with Time of Day

How often are the symptoms present?

- Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

How does this pain/symptom affect your movement? Inflexibility Stiffness Spasms Cramps

What makes your problem **better**?

- Nothing Lying Down Sitting Standing Walking Lifting Carrying Pushing Pulling
 Movement Exercise Inactivity Sleep Stretching Hot Water Weather Other _____

What makes your problem **worse**?

- Nothing Lying Down Sitting Standing Walking Lifting Carrying Pushing Pulling
 Movement Exercise Inactivity Sleep Stretching Hot Water Weather Other _____

Are you currently receiving other therapy/treatment? No Yes

If yes, please describe: _____

How would you grade your general stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed

Physical activity at work: Sitting >50% of workday Light Manual Labor Manual Labor Heavy Manual Labor

General physical activity: No Regular Exercise Light Exercise Strenuous Exercise

Has your weight recently changed by more than 10 pounds? No Gain Loss

Patient Signature: _____ **Doctor Signature:** _____

Date: _____