



FORTIER CHIROPRACTIC HEALTHCARE

Auto Accident • Work Injury • Back Pain • Headache • Sports Injury

220 Fifth Avenue SW Albany, OR 97321 Ph.(541) 926-0510 Fax(541) 926-5540

www.fortierchiropractic.com

CONFIDENTIAL PATIENT DATA

Name: _____ Date of Birth: _____ Date: _____
 Height: _____ Weight: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1. _____
 2. _____
- Please list ALL prescription medication you are taking and WHY:

Symptoms are worse: <input type="checkbox"/> morning <input type="checkbox"/> afternoon <input type="checkbox"/> night	
When did it occur?	Is it getting worse? Y / N
Symptoms developed from: <input type="checkbox"/> Work <input type="checkbox"/> Auto Accident <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	
Symptoms: <input type="checkbox"/> og dna emoc <input type="checkbox"/> are constant	
Does it bother you: work / sleep / other (please specify)	
Have you ever had these symptoms before: Y / N	If yes, when?
What activities make symptoms worse? <input type="checkbox"/> Bending <input type="checkbox"/> Reaching <input type="checkbox"/> Straining at Stool <input type="checkbox"/> Coughing <input type="checkbox"/> Sitting <input type="checkbox"/> Turning Head <input type="checkbox"/> Lifting <input type="checkbox"/> Sneezing <input type="checkbox"/> Walking <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing	
What activities make symptoms better? <input type="checkbox"/> Bending <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Standing <input type="checkbox"/> Lying Down <input type="checkbox"/> Turning Head <input type="checkbox"/> Reaching <input type="checkbox"/> Walking	
Symptoms feel like: <input type="checkbox"/> Deep/dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stiffness <input type="checkbox"/> Shooting <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Cramps <input type="checkbox"/> Swelling <input type="checkbox"/> Catching/locking <input type="checkbox"/> Popping/clicking <input type="checkbox"/> Electrical	
Have you seen a Chiropractor before? Y / N	If yes, when?
Name of primary care physician:	
(Women) Are you pregnant? Y / N Nursing? Y / N Taking birth control? Y / N	
Most of your day is spent: <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> walking <input type="checkbox"/> other (specify)	

Have you been treated by a physician for any health condition in the last year? Yes No
 Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY: 1. _____ Date: _____
 2. _____ Date: _____
 3. _____ Date: _____

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No
 ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____
Job Auto Other 2. _____ Date: _____



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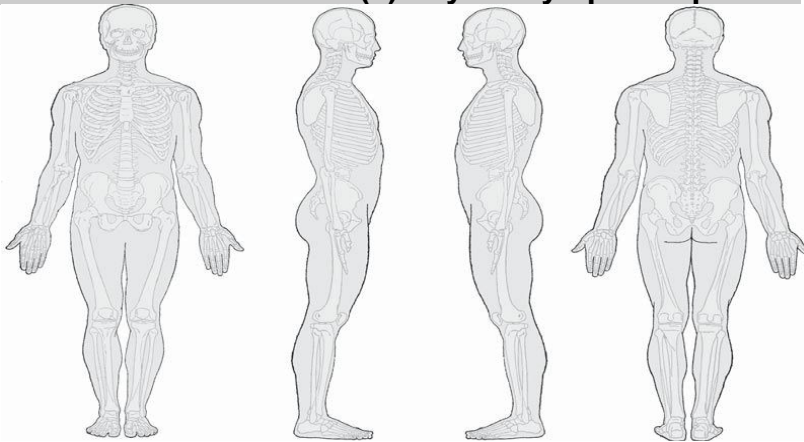
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Please check any **ADDITIONAL** symptoms you may be experiencing

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion constipation
- depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever head seems too heavy
- headaches insomnia light bothers eyes loss of balance loss of smell loss of taste low resistance to colds
- muscle jerking numbness in fingers numbness in toes pins and needles in arms pins and needles in legs
- ringing in ears shortness of breath stiff neck stomach upset

Please mark the area(s) of your symptoms/pain



Habits	None	Light	Mod.	Heavy
- Alcohol				
- Coffee				
- Tobacco				
- Exercise				
- Sleep				
- Sugar				

Additional Information:

Please Rate Your Pain/Discomfort:

0 ----- 5 ----- 10
 (No pain/discomfort) (Severe)

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

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

- | | | | | | | | | | |
|----------------------------|----------------------------|--|----------------------------|----------------------------|---|----------------------------|----------------------------|----------------------------|------------------|
| <input type="checkbox"/> S | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> M | <input type="checkbox"/> F | neck pain |
| <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"/> | nervousness |
| <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"/> | numbness |
| <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"/> | polio |
| <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"/> | poor circulation |
| <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"/> | hepatitis |
| <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"/> | rheumatic fever |
| <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"/> | rheumatism |
| <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"/> | scarlet fever |
| <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"/> | serious injury |
| <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"/> | sinus trouble |
| <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"/> | tuberculosis |
| <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"/> | venereal disease |
| <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"/> | |