



# 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](http://www.fortierchiropractic.com)

## CONFIDENTIAL PATIENT DATA

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE LIST PRESENT MAJOR COMPLAINTS:**

1. \_\_\_\_\_
2. \_\_\_\_\_

**Please List ALL prescription medication you are taking and WHY:** \_\_\_\_\_  
 \_\_\_\_\_

<b>How long have you had this condition?</b>	<b>Is it getting worse? Y / N</b>
<b>What was the initial cause?</b>	
<b>Does it bother you:</b> work / sleep / other (please specify)	
<b>Symptoms:</b> <input type="checkbox"/> come and go <input type="checkbox"/> came on gradually <input type="checkbox"/> came on suddenly (date)	
<b>Symptoms are:</b> <input type="checkbox"/> worse in AM <input type="checkbox"/> worse in PM	
<b>Have you ever had these symptoms before:</b> Y / N	<b>If yes, when?</b>
<b>What activities make symptoms worse?</b>	
<b>What activities make symptoms better?</b>	
<b>Symptoms feel like:</b> <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	
<b>Have you seen a Chiropractor before?</b> Y / N	<b>If yes, when?</b>
<b>Name of primary care physician:</b>	
<b>Date of last physical exam:</b>	<b>Date of last physician visit:</b> <b>Reason:</b>
<b>(Women) Are you pregnant?</b> Y / N <b>Nursing?</b> Y / N <b>Taking birth control?</b> Y / N	
<b>Most of your day is spent:</b> <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> walking <input type="checkbox"/> other (specify)	

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

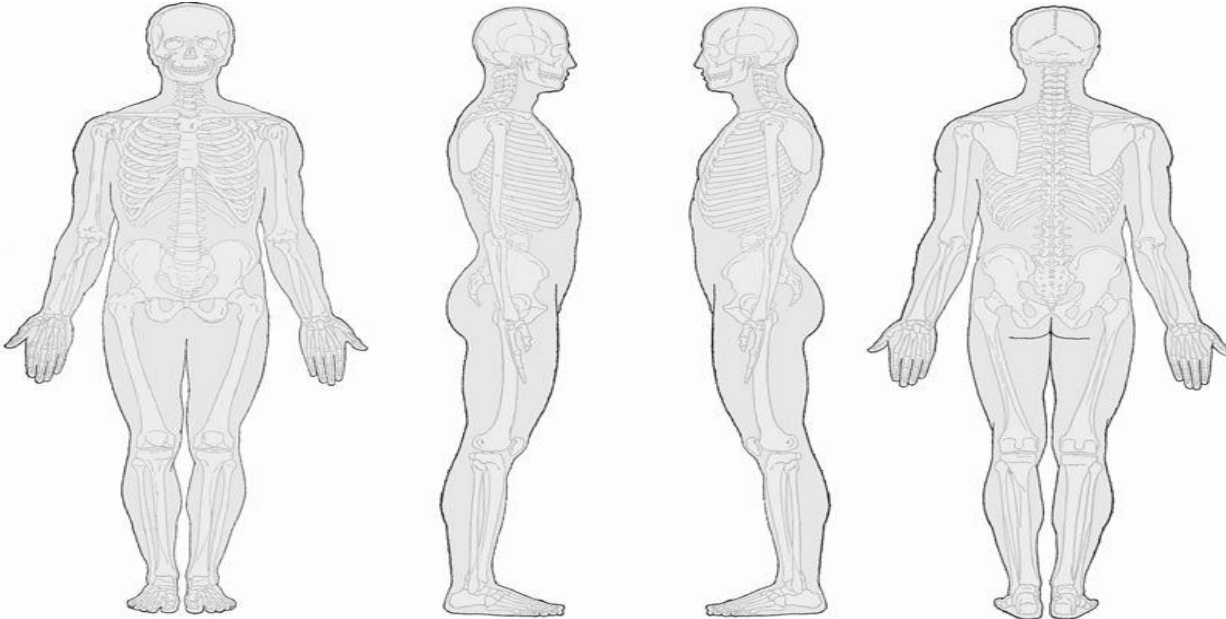
- |   |  |   |   |                                       |
|---|--|---|---|---------------------------------------|
| <input type="checkbox"/> blurred vision       | <input type="checkbox"/> buzzing in ears     | <input type="checkbox"/> cold feet          | <input type="checkbox"/> concentration loss/confusion | <input type="checkbox"/> stiff neck   |
| <input type="checkbox"/> constipation         | <input type="checkbox"/> diarrhea            | <input type="checkbox"/> dizziness          | <input type="checkbox"/> face flushed                 | <input type="checkbox"/> ears ringing |
| <input type="checkbox"/> headaches            | <input type="checkbox"/> insomnia            | <input type="checkbox"/> light bothers eyes | <input type="checkbox"/> loss of balance              | <input type="checkbox"/> nervousness  |
| <input type="checkbox"/> muscle jerking       | <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> numbness in toes   | <input type="checkbox"/> pins/needles in arms         | <input type="checkbox"/> tension      |
| <input type="checkbox"/> pins/needles in legs | <input type="checkbox"/> loss of smell       | <input type="checkbox"/> loss of taste      | <input type="checkbox"/> fainting                     | <input type="checkbox"/> chest pain   |
| <input type="checkbox"/> shortness of breath  | <input type="checkbox"/> stomach upset       | <input type="checkbox"/> trouble sleeping   | <input type="checkbox"/> depression                   | <input type="checkbox"/> fatigue      |
| <input type="checkbox"/> cold hands           | <input type="checkbox"/> cold sweats         | <input type="checkbox"/> fever (last 3 mo.) | <input type="checkbox"/> loss of memory               |                                       |



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



Please Rate Your Pain/Discomfort:

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

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

**FAMILY HEALTH HISTORY:** Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS