Welcome to Dr. Connie's Chiropractic & Wellness Center

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Date of Birth: _____ I am __married; __single; __ divorced; __ widowed; __adopted

Spouse/Partner's Name: _____ I am ___female; ___male

Referred by: ___Friend/Family: name _____; ___Internet; ___ Insurance; ___ Yellow Pages

Please ***initial*** the contact options you prefer, giving Dr. Connie your permission to contact you in that way.

____ May call my **home phone** number: _____ - _____ - _____
____ This is my **preferred number**. _____ You may leave a message on my home voicemail.
____ May leave a message with the person that answers this phone.

____ May call my **cell phone** number: _____ - _____ - _____
____ This is my **preferred number**. _____ You may leave a message on my cell voicemail.
____ May leave a message with the person that answers this phone.

____ May call my **work phone** number: _____ - _____ - _____
____ This is my **preferred number**. _____ You may leave a message on my work voicemail.
____ May leave a message with the person that answers this phone.

____ May send **text appointment reminders** to my cell phone.
My cell phone provider is: _____
____ May **email appointment reminders** to my email address (in section above).

____ Yes, I want to receive Dr. Connie's electronic monthly newsletter to my email address.

Payment for services will by: ____Self; _____Health Insurance; ____ Auto Insurance; ____ Other

Insurance Company_____

Patient's Occupation: _____ Employer: _____

Is the patient covered by more than one insurance company? ___Yes ____ No

Name of secondary insurance company: _____

Name of Insured (if different from patient's): _____

Insured's Employer: _____ Insured's Date of Birth: _____

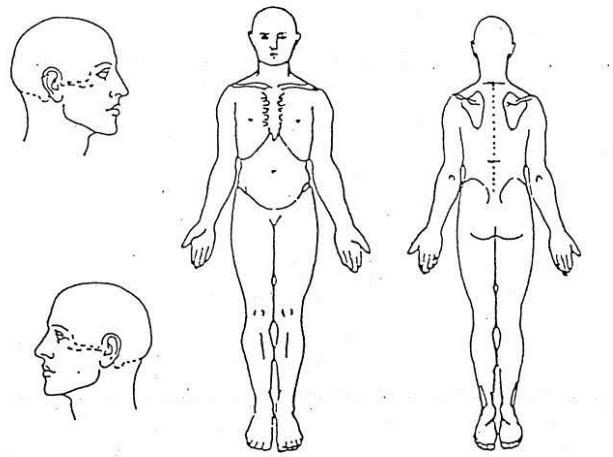
Have you ever been to a chiropractor before? ___Yes ____ No

If yes, have you ever had a bad reaction to an adjustment? ___Yes ____ No

Have you had any auto or other accident? ___Yes ____ No Date: _____

Describe: _____

Please Mark Your Areas Of Pain On The Diagrams Below:



Main reason for consulting our office:

___ Become pain free

___ Explanation of my condition(s)

___ Learn how to care for my condition(s)

___ Reduce my symptoms

___ Resume normal activity level

What is your **major** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Condition is on ___the Right Side ___ the Left Side ___Both Sides

Have you had this condition in the past? ___ Yes ___ No

Please rate your pain on a scale of 1-10 (0 = no pain and 10 = excruciating pain)

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10

How is your condition changing? ____ None ___Same ____% Better ____ % Worse

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect / 10 = all activities affected) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What is the nature of your symptoms: ___ Sharp ___ Dull ___ Numb ___ Burning ___ Shooting

___Tingling ___ Radiating ___ Tight(ness) ___ Stabbing ___ Throbbing

__Other _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience you symptoms?

___ Constantly (76 - 100% of the day) ___ Frequently (51 - 75% of the day)

___ Occasionally (50 – 26% of the day) ___ Intermittently (0 – 25% of the day)

What activities aggravate your condition (working, exercise, etc.)? _____

_____

What is your **second** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Condition is on ___the Right Side ___ the Left Side ___Both Sides

Have you had this condition in the past? ___ Yes ___ No

Please rate your pain on a scale of 1-10 (0 = no pain and 10 = excruciating pain)

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10

How is your condition changing? ____ None ___Same ____% Better ____ % Worse

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect / 10 = no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What is the nature of your symptoms: ___ Sharp ___ Dull ___ Numb ___ Burning ___ Shooting
___Tingling ___ Radiating ___ Tight(ness) ___ Stabbing ___ Throbbing

__Other _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience you symptoms?

___ Constantly (76 - 100% of the day) ___ Frequently (51 - 75% of the day)

___ Occasionally (50 – 26% of the day) ___ Intermittently (0 – 25% of the day)

What activities aggravate your condition (working, exercise, etc.)? _____

_____

What is your **next** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Condition is on ___the Right Side ___ the Left Side ___Both Sides

Have you had this condition in the past? ___ Yes ___ No

Please rate your pain on a scale of 1-10 (0 = no pain and 10 = excruciating pain)

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10

How is your condition changing? ____ None ___Same ____% Better ____ % Worse

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect / 10 = no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What is the nature of your symptoms: ___ Sharp ___ Dull ___ Numb ___ Burning ___ Shooting
___Tingling ___ Radiating ___ Tight(ness) ___ Stabbing ___ Throbbing

__Other _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience you symptoms?

___ Constantly (76 - 100% of the day) ___ Frequently (51 - 75% of the day)

___ Occasionally (50 – 26% of the day) ___ Intermittently (0 – 25% of the day)

What activities aggravate your condition (working, exercise, etc.)? _____

_____

Medical/ Family History **S = Self** **M – Mother** **F = Father**

Please indicate which conditions have been experienced by you and/or your parents by marking the appropriate boxes. ***Note; if you are adopted please mark conditions of your birth parents only – if known.**

S	M	F		S	M	F		S	M	F	
__	__	__	Adopted	__	__	__	Dislocated Joints	__	__	__	Nervousness
__	__	__	AIDS	__	__	__	Indigestion	__	__	__	Numbness
__	__	__	Anemia	__	__	__	Epilepsy	__	__	__	Polio
__	__	__	Arthritis	__	__	__	German measles	__	__	__	Poor circulation
__	__	__	Asthma	__	__	__	Headaches	__	__	__	Reproductive disorders
__	__	__	Back pain	__	__	__	Heart trouble	__	__	__	Rheumatic fever
__	__	__	Bladder trouble	__	__	__	Hepatitis	__	__	__	Rheumatism
__	__	__	Bone fracture	__	__	__	High blood pressure	__	__	__	Scarlet Fever
__	__	__	Bowel control loss	__	__	__	HIV	__	__	__	Serious injury
__	__	__	Cancer	__	__	__	Kidney disorder	__	__	__	Sinus trouble
__	__	__	Chest pain	__	__	__	Menstrual cramps	__	__	__	Stroke
__	__	__	Concussion	__	__	__	Multiple Sclerosis	__	__	__	Tuberculosis
__	__	__	Convulsions	__	__	__	Muscular Dystrophy	__	__	__	Venereal disease
__	__	__	Diabetes	__	__	__	Neck pain				

Do you have any allergies? Seasonal Foods? Plants? Materials? Scents?

_____

Surgical History

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

List medications you are taking: _____

_____

Do you have any metal implants? ___ No ___ Yes Where: _____

Do you have any breast implants? ___ No ___ Yes Where: _____

Have you ever been gunshot? ___ No ___ Yes Where: _____

In case of an emergency, please notify:

Name: _____ Relationship: _____

Address: _____

Home phone: _____ Cell: _____ Work: _____