

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: _____

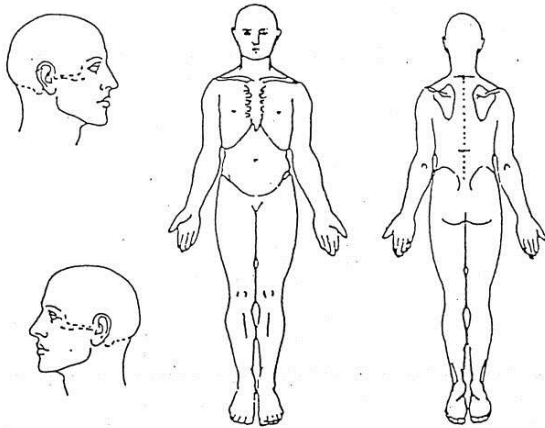
Have you ever been to a chiropractor before? ___Yes ___No

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 intensity of your symptoms:

Minimum Mild Moderate Severe Unbearable None

What is the nature of your symptoms:

Burning Dull Numb Radiating Sharp Shooting Stabbing

Tight(ness) Tingling 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 intensity of your symptoms:

___ Minimum ___ Mild ___ Moderate ___ Severe ___ Unbearable ___ None

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

___ Shooting ___ Stabbing ___ Tight(ness) ___ Tingling ___ Throbbing

___ Other _____

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

How often do you experience your 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 intensity of your symptoms:

___ Minimum ___ Mild ___ Moderate ___ Severe ___ Unbearable ___ None

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

___ Shooting ___ Stabbing ___ Tight(ness) ___ Tingling ___ Throbbing

___ Other _____

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

How often do you experience your 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: _____