|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Last Name | Patient First Name | MI | Gender\_\_\_M \_\_\_F | DOB (MM/DD/YYYY  / / |
| Address- Street | City | State | Zip |
| Email | Cell | Can we contact you by email and/or cell? \_\_\_Y \_\_\_N | Is the visit related to injury?\_\_\_Work \_\_\_ Auto \_\_\_Other |
| Employer | Primary Insurance | Secondary Insurance |

**\*If using insurance, please bring ID card(s) to first visit.**

|  |  |  |  |
| --- | --- | --- | --- |
| Reason(s) for visit in order of importance: | Date First Noticed: | Using scale in which 0 is no pain or symptoms and 10 is severe, mark the number that best reflects your condition: | How much of the time do you notice this symptom: |
| 1 |  | \_\_1\_\_2\_\_3\_\_4\_\_5\_\_6\_\_7\_\_8\_\_9\_\_10 | \_\_0-25%\_\_26-50%\_\_51-75%\_\_76-100% |
| 2 |  | \_\_1\_\_2\_\_3\_\_4\_\_5\_\_6\_\_7\_\_8\_\_9\_\_10 | \_\_0-25%\_\_26-50%\_\_51-75%\_\_76-100% |
| 3 |  | \_\_1\_\_2\_\_3\_\_4\_\_5\_\_6\_\_7\_\_8\_\_9\_\_10 | \_\_0-25%\_\_26-50%\_\_51-75%\_\_76-100% |
| 4 |  | \_\_1\_\_2\_\_3\_\_4\_\_5\_\_6\_\_7\_\_8\_\_9\_\_10 | \_\_0-25%\_\_26-50%\_\_51-75%\_\_76-100% |

**For the Reasons listed above, please check if it is Better or Worse with any of the following:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | HEATBetter Worse | COLDBetter Worse | RESTBetter Worse | ACTIVITYBetter Worse | WHICH ACTIVITIES MOST AGGRAVATING |
| **Reason 1** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  |
| **Reason 2** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  |
| **Reason 3** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  |
| **Reason 4** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  **\_\_\_ \_\_\_** |  |

During what time of the day do you feel worse? \_\_\_\_ am \_\_\_\_ pm \_\_\_ constant Do you sleep well? \_\_\_ Y \_\_\_ N

Have you consulted any other physician for current complaints? \_\_\_ Y \_\_\_ N Previous chiropractic care? \_\_\_ Y \_\_\_ N

Are you currently under the care of a medical doctor for an ongoing condition? \_\_\_ Y \_\_\_\_ N

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an overnight stay in a hospital or a surgical procedure of any kind? \_\_\_ Y \_\_\_ N

If yes, please describe for what and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? \_\_\_\_ Y \_\_\_ N If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please continue on page 2

**PERSONAL HISTORY -** Please check the boxes that apply to you:

Current Conditions/Symptoms:

|  |  |  |  |
| --- | --- | --- | --- |
|  \_\_ difficulty swallowing |  \_\_\_ electric shocks in arms or legs when moving neck | \_\_\_ leg pain that worsens with exercise but is relieved with rest |  \_\_\_ loss of feeling in inner thighs, feet or hands |
| \_\_\_ incontinence | \_\_\_ facial numbness | \_\_\_ severe pain that interrupts sleep | \_\_\_ unable to balance when standing or walking |
| \_\_\_ recent unexplained weight loss | \_\_\_ recent progressive muscle weakness or shaking | \_\_\_ recent or current fever over 102° | \_\_\_ blurred or double vision, dizziness, nausea or faintness when moving neck |
| \_\_\_ recent head trauma | \_\_\_ memory loss | \_\_\_ osteoporosis | \_\_\_ seizure disorder |

Previously diagnosed condition/medical history:

|  |  |  |
| --- | --- | --- |
| \_\_\_ congenital bone or joint disorder | \_\_\_ rheumatoid arthritis | \_\_\_ severe degenerative arthritis |
| \_\_\_ past compression fracture | \_\_\_ history of heart attack | \_\_\_ history of stroke or aneurysm |
| \_\_\_ past or current history of cancer | \_\_\_ diabetes with cold, burning or numb feet | \_\_\_ immune suppression such as from chemo, organ transplant, etc. |
| \_\_\_ lupus \_\_\_ gout | \_\_\_ ankylosing spondylitis | \_\_\_ 3 or more months of steroid medications or IV drugs  |

**FAMILY HISTORY** – please check the boxes that apply to any biological relatives:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ autoimmune disorder | \_\_\_ cancer | \_\_\_ heart disease | \_\_\_ diabetes |
| \_\_\_ mental illness | \_\_\_ kidney disease | \_\_\_ seizure disorder | \_\_\_ Alzheimer’s/dementia |

***I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of Wayne E. Pratt, DC to other health professionals to whom I may be referred and/or the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.***

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_

***If patient required assistance to complete, sign name and state relationship (ex: parent, translator):***

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_