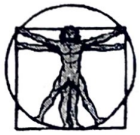
For office use only:
Pt.#:
Computer #:



FARMVILLE CHIROPRACTIC CENTER

THERAPIES FOR PAIN SINCE 1982

Date:

Patient Information

Name: Last First M.I.		Marital status: S M D W SSN: - -
Sex: M ☐ F ☐	Age:	Date of Birth:
Home phone:	Work phone:	Cell:
Home address:	City/State/Zip:	
Family Medical Doctor:	Office location:	
Employer:		
Work address:		

Person to contact in emergency:
Address and phone number:

Person responsible for payment:	Relationship:
Address and phone number:	

Insurance type:	Name of insured:
SSN of insured: - -	Birthdate of insured:

How did you hear about our office?_____

Have you ever visited a chiropractor before? If so, whom did you visit and when? _____

_____

Problem Description

What is the main problem that brings you to this office? _____

_____

_____

How long have you had this problem? _____

_____

Have you been given a diagnosis for this problem? If so, what is it? _____

_____

Is pain is due to an injury? If so, is it work related? Please explain._____

_____

_____

_____

To what extent does this problem interfere with your daily activities?_____

_____

_____

_____

Is there anything that makes you feel better? _____

_____

_____

What other treatments have you tried, and what has been your response?_____

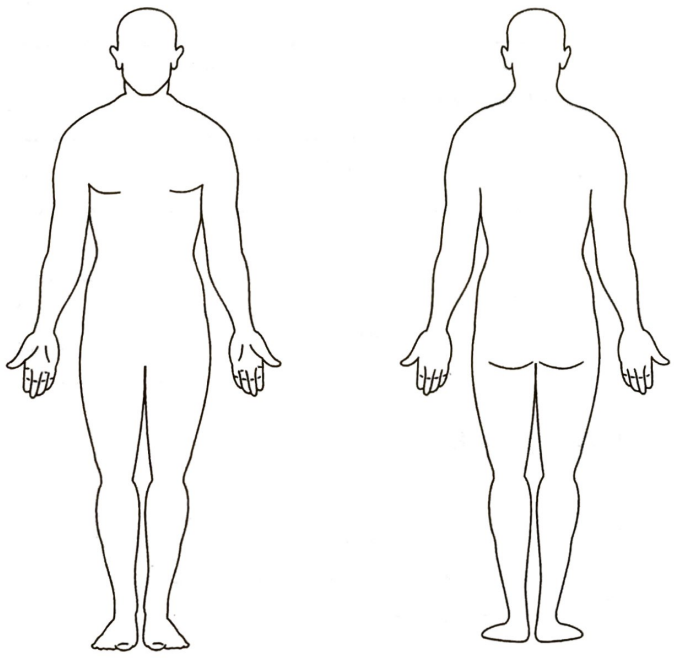
_____

_____

_____

Muscular-Skeletal

Indicate areas where you experience pain.



Please check the following which best describes the nature of your pain.

___ Sharp
___ Dull
___ Throbbing
___ Cramping
___ Burning
___ Cutting
___ Tight
___ Heavy
___ Moving
___ Stabbing
___ Worse in the day
___ Worse at night
___ Worse when humid
___ Worse when dry
___ Worse when cold
___ Aggravated by diet
___ Worse with stress

Medical History

Please list your past surgeries and their dates: _____
_____
_____
_____

Please indicate any of the following significant illnesses and the date of occurrence.

___ Cancer
___ Heart Disease
___ **Stroke**
___ **High blood pressure**
___ Diabetes
___ **Scoliosis**
___ Thyroid Disease
___ Hepatitis
___ Seizures
___ Other:_____

Please check if you have experienced any of the following ***in the last 3 months.***

General

___ Change in appetite
___ Hearing loss
___ Localized weakness
___ Peculiar tastes or smells
___ Poor sleeping
___ Puffiness or swelling
___ Easy to bleed or bruise
___ Strong thirst
___ Sudden energy drop
___ Sweat easily
___ Poor balance
___ Cravings
___ Tremors
___ Night sweats
___ Fatigue
___ Weight loss or gain
___ Arthritis
___ Other:_____

Skin and Hair

___ Rashes
___ Skin ulcers
___ Itching
___ Hives
___ Eczema
___ Hair loss

Head, Eyes, Nose, and Throat

___ Dizziness
___ Cataracts
___ Teeth grinding
___ Headaches
___ Noses bleeds
___ Migraine
___ Ear ringing
___ Earaches
___ Lip or tongue sores
___ Eye pain
___ Spots in front of eyes
___ Sinus problems
___ Concussions
___ Glasses
___ Eye Strain
___ Poor hearing
___ Jaw click
___ Recurrent sore throat
___ Facial pain
___ Blurry vision

Cardiovascular

___ High blood pressure
___ Cold hands or feet
___ Swelling of hands
___ Swelling of feet
___ Low blood pressure
___ Blood clots
___ Phlebitis
___ Fainting
___ Irregular heartbeat
___ Palpitations
___ Chest pains
___ Light headedness

Respiratory

___ Cough
___ Phlegm
___ Asthma
___ Bronchitis
___ Coughing up blood
___ Painful breathing
___ Difficult breathing
___ Pneumonia
___ Other:_____

Gastro- Intestinal

___ Nausea
___ Bad breath
___ Chronic laxative use
___ Blood in stools
___ Indigestion
___ Rectal Pain
___ Constipation
___ Black stools
___ Hemorrhoids
___ Vomiting
___ Diarrhea
___ Abdominal pain
___ Intestinal gas
___ Loss of appetite

Genito-Urinary

___ Painful urination
___ Decrease in urine flow
___ Kidney stones
___ Blood in Urine
___ Urgency to urinate
___ Cloudy urine
___ Frequent urination
___ Genital sores
___ Frequent night urination
___ Unable to hold urine
___ Herpes

Neuro- Psychological

___ Seizures
___ Twitches
___ Bad temper
___ Poor memory
___ Irritability
___ Numb body areas
___ Lack of coordination
___ Loss of Balance
___ Anxiety
___ Tremors
___ Depression
___ Stress
___ Mood swings
___ Other: _____

Diet and Personal Habits

Do you have any food or other allergies? If so, what? _____
_____

Do you diet or restrict your food intake? Explain: _____
_____

Do you have a regular exercise program? Describe._____
_____

Do you smoke? If so, how much? _____

Do you drink alcoholic beverages? If so, how much per week? _____
_____

Do you drink caffeinated beverages, and if so, how much per week? _____
_____

Please list any medications, vitamins, or supplements that you are taking, and why you are taking them. _____
_____
_____
_____

Thank you for taking the time to fill out this form.
All information is strictly confidential.