Malina CHIROPRACTIC and Wellness Center

CONFIDENTIAL PATIENT DATA

The following information is needed in order to better serve you. Please complete all questions. If you need any assistance completing this form, please ask the receptionist

Today's Date: _____

Name *(Last, First, M.I.):* _____ ☐ M ☐ F **DOB:** _____

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ **Cell phone number:** _____

Work phone number: _____ **Email:** _____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Payment/Insurance Information: ☐ Self ☐ Health Insurance

Health Insurance Carrier: _____ **Insurance Card ID Number:**_____

		AGE
Children	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Occupation:_____ **Employer:** _____

Name of Spouse or Nearest Relative: _____ **Phone number:** _____

Referred to this office by: ☐ Friend/Family Member- Name? _____

☐ Clinic Location ☐ Insurance Company ☐ Google ☐ Event ☐ Website ☐ Other: _____

Have you been adjusted by a chiropractor before? ☐ Yes ☐ No

Reason for those visits? _____

Approximate date of last visit? _____

Whom may we contact in case of emergency? _____

Name: _____ **Phone Number:** _____ **Relationship:** _____

Patients Name:_____ **Date**: _____/_____/_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Mark the areas of pain on the figures below and then circle on the pain scale from 0-10 the pain you feel with this condition. 10 being the worst pain you have ever felt and 0 being no pain at all.

Area of complaint **(Rate 1-10)** **Please mark an X where you have pain or other symptoms**

1. _____ **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain**

WHEN DID THIS CONDITION BEGIN?

_____

HAS THIS CONDITION:

Gotten worse Gotten better

Stayed constant Comes and goes

Type of pain: Stiffness, Burning, Numb/Tingling, Sharp, Soreness/Achy

2. _____ **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain**

WHEN DID THIS CONDITION BEGIN?

_____

HAS THIS CONDITION:

Gotten worse Gotten better

Stayed constant Comes and goes

Type of pain: Stiffness, Burning, Numb/Tingling, Sharp, Soreness/Achy

3. _____ **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain**

WHEN DID THIS CONDITION BEGIN?

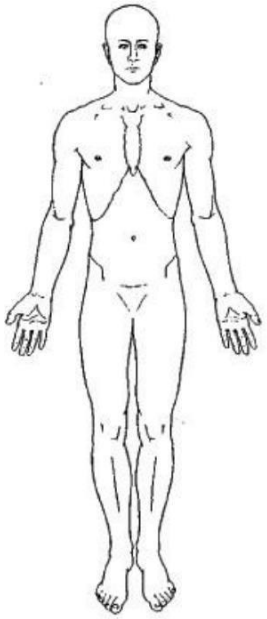
_____

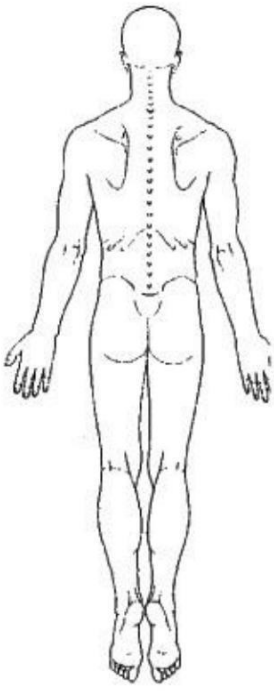
HAS THIS CONDITION:

Gotten worse Gotten better

Stayed constant Comes and goes

Type of pain: Stiffness, Burning, Numb/Tingling, Sharp, Soreness/Achy





Name of doctors previously seen for present condition:

1. _____

2. _____

Patients Name: _____ **Date**: ____/_____/____

MEDICATIONS & SOCIAL HISTORY (circle which apply)

Are you taking any herbs/supplements?	☐ No	☐ Yes, what kind? _____	
Are you…	☐ Right handed	☐ Left handed	
Tobacco use:	☐ No	☐ Yes, Cigarettes/Day _____	
Alcohol use:	☐ No	☐ Yes, Drinks/Day _____	
Recreational drug use:	☐ No	☐ Yes	
Do you spend time on the computer?	☐ No	☐ Yes	
Is your computer station ergonomically correct?	☐ No	☐ Yes	
Do you exercise regularly?	☐ No	☐ Moderate	☐ Daily
Do you wear:	☐ None	☐ Heel lifts	☐ Insoles
How is your diet?	☐ Balanced	☐ Not Balanced	
How is your sleep schedule?	☐ <8 hrs/night	☐ >=8 hrs/night	☐ Insomnia
How many ounces of water do you drink daily	☐ <64 oz/day	☐ >=64 oz/day	☐ Rarely

MEDICATION HISTORY (*Please write 'none' or 'N/A' if this question does not apply)*

Medication Name	For What Medical Condition	Start Date	Dosage

Do you have any seasonal, medication, systemic allergies or intolerances? No

Type of Allergy	Reaction	Onset date	Additional comments

Patients Name: _____ **Date**: ____/_____/_____

MEDICAL HISTORY

SURGICAL HISTORY (*Please write 'none' or 'N/A' if this question does not apply)*

Surgery	Date	Surgery	Date
1.		3.	
2.		4.	

Have you ever had any type of implant? No Yes, what kind? _____

Have you ever sustained a gunshot wound? No Yes, where? _____

Date of Last Physical Exam and Doctor: _____

Women Only:

Are you pregnant? No Yes, due date? _____

Date of last menstrual cycle: _____/_____/_____

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have permission to perform an X-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

_____ _____

Patient Signature Today's date

Accident History (circle which apply)

(Please write 'none' or 'n/a' if this question does not apply):

Job Auto Other:_____ Date: / /

Job Auto Other:_____ Date: / /

Job Auto Other:_____ Date: / /

Family History

	Mother	Father	Brother	Sister
Arthritis				
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Stroke				
Thyroid				
Other: _____				

Patients Name: _____ **Date**: _____/_____/_____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			