

CHICAGO CHIROPRACTIC & SPORTS MEDICINE

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PATIENT INFORMATION

First Name: _____ Last Name: _____

If patient is under age 18, Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: _____ Birthdate: _____ Age: _____

Marital Status: Married Single Domestic Partner Other: _____

Occupation: _____ Employer/School: _____

Referred by: _____ Doctor Family Friend Trainer Other: _____

CONTACT INFORMATION

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Emergency Contact Name(s): _____

Phone: _____ Relation to Emergency Contact: _____

May we communicate with the above-named emergency contact, if needed? Yes No

PATIENT CONDITION

Chief Complaint(s), please list in order of severity: 1: _____

2: _____ 3: _____

Is this visit due to an accident/injury? Yes No If yes, is this: Sports/Activity Related Auto Accident Claim

Workers Comp Claim Personal Injury Case Other: _____

Date your current symptoms appeared/accident date? __/__/____

How are symptoms changing with time: Getting Better Not Changing Getting Worse

How do you think this problem began? _____

Have you previously had the same condition? Yes No

If yes, please explain: _____

Mark an X on the picture in all locations where you have pain, numbness, or tingling. Rate the severity of your pain on a scale from 1 (least pain) through 10 (severe pain) at each location.

Type of Pain: Stiffness Swelling Throbbing Numbness Dull
 Aching Shooting Burning Tingling Cramps Sharp
 Other: _____

Do you consider this problem to be severe? Yes No

Explain : _____

How often do you experience this pain?

Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

Does your pain wake you up at night? Yes No

Explain: _____

Does your pain interfere with your: Work Sleep Daily Routine Recreation Other

Explain: _____

Activities that make symptoms worse: Sitting Standing Walking Bending Lying Down

Explain: _____

Activities that make symptoms better: Sitting Standing Walking Bending Lying Down

Explain: _____

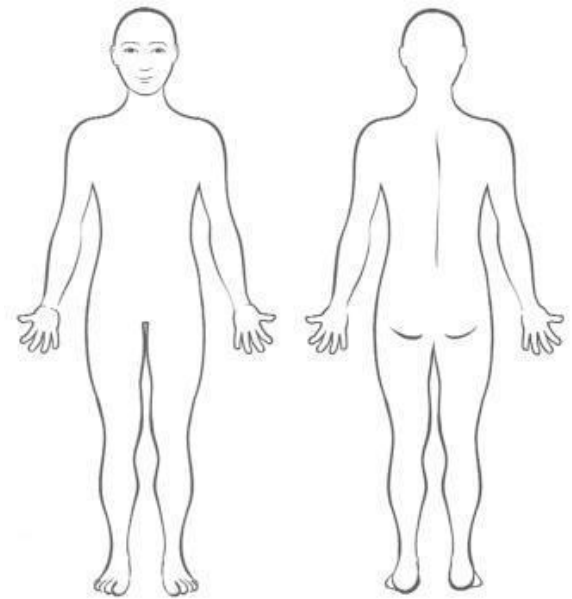
Have you seen other practitioners for this injury/condition? (Check all that apply):

Chiropractor ER Physician Massage Therapist Orthopedist Physical Therapist Primary Care Physician
 Neurologist No One Other: _____

Treatment you already received for your injury/condition: Medications Physical Therapy Chiropractic Services

None Surgery Other: _____

Name(s) of other practitioner(s) who have treated you for your condition: _____



MEDICAL HISTORY

Have you ever been treated for any other medical conditions? Yes No

Explain: _____

Date of last physical exam: __/__/____ (if known) Were there any findings? Yes No Explain: _____

Height: _____ Weight: _____ Normal blood pressure (if known): _____

Are you pregnant or plan to become pregnant? Yes No

Have you had recent X-Rays/MRI's/Imaging? Yes No Explain _____

Have you ever (check all that apply):

Broken Bone(s): If yes, please list all and date of occurrence: _____

Been Hospitalized: If yes, please list all and date of occurrence: _____

Been in Auto Accident(s): If yes, please list all, date of occurrence, and any injuries: _____

Had Sprains/Strains: If yes, please list all, date of occurrence, and treatment required: _____

Been Struck Unconscious: When: _____ For how long: _____

Had Surgery If yes, please list all and date of occurrence: _____

What medications are you taking and for what conditions? (Please list dosage and frequency): _____

What vitamins, minerals, or herbs do you currently take? (Please list dosage and frequency): _____

List any family member – present and past health conditions (ex: heart disease, cancer, diabetes, arthritis, etc.): _____

SOCIAL INFORMATION

Please indicate, during a typical day, how much of the following you do?

Sit: Most of the day Half the day A little bit of the day

Stand: Most of the day Half the day A little bit of the day

Computer Work: Most of the day Half the day A little bit of the day

On the Phone: Most of the day Half the day A little bit of the day

What type(s) of exercise do you do? Please list all that apply.

Type: _____ Frequency: Less than once a week 1-2 times a week 3-4 times a week 5-7 times a week

Duration: _____ Intensity Level: _____

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Duration: _____ Intensity Level: _____

Type: _____ Frequency: Less than once a week 1-2 times a week 3-4 times a week 5-7 times a week

Duration: _____ Intensity Level: _____

What other activities do you participate in? _____

ADDITIONAL INFORMATION

Please check all that apply:	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU SUFFERED FROM (Check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Abdominal Scar | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fractures | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate Trouble |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Headache | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Balance Issues | <input type="checkbox"/> Hernia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Problems of Insomnia |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Spinal Curvatures |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease/Infection | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pain/Conditions | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Other (list any/all medical conditions not listed above): |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Nausea | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neck Pain or Stiffness | |
| <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Nervousness | |
| <input type="checkbox"/> Eye Pain or Difficulty | <input type="checkbox"/> Osteoporosis | |