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: _____ **Emergency Contact Relation:** _____

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: _____

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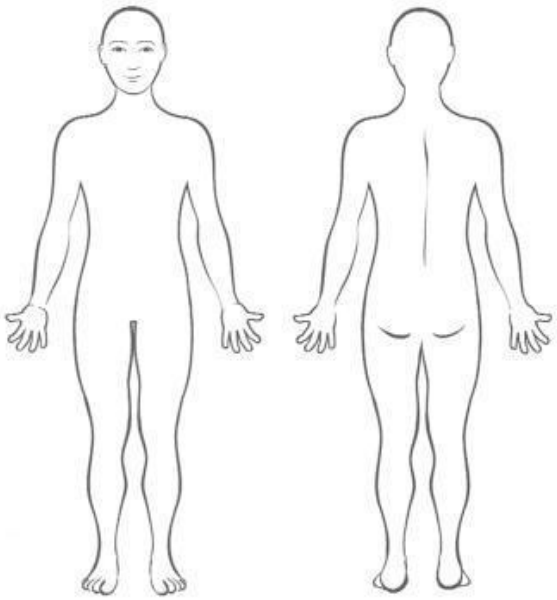
Mark an X on the picture in all locations where you have pain, numbness, or tingling. Rate the severity of your pain on a scale from 1 (least pain) through 10 (severe pain) at each location.



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: _____

_____

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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.): _____

_____

_____

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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:** _____

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:** _____

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	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

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HAVE YOU SUFFERED FROM (Check all that apply):

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