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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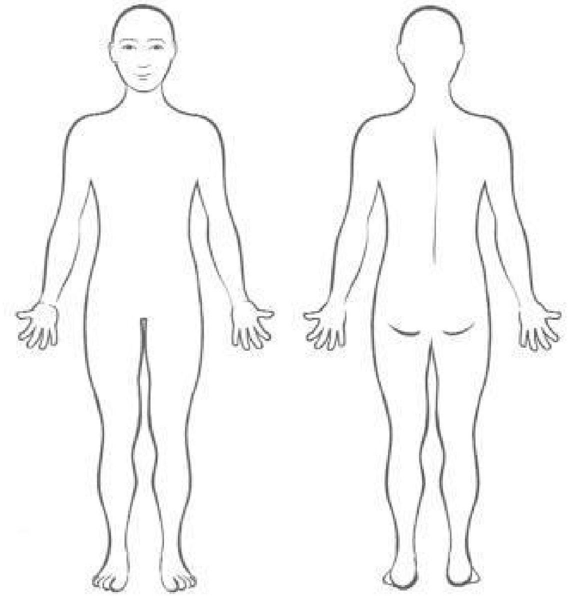

Mark an X on the picture in all locations where you have pain, numbness, or tingling. Rate the severity of your pain on a scale from 1 (least pain) through 10 (severe pain) at each location.

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?

Does your pain wake you up at night? ☐ Yes ☐ No

Expla____________________

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): ______________________________

____

____

List any 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.

____

HAVE YOU SUFFERED FROM (Check all that apply):

- ☐ Abdominal Scar
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cesarean Section
- ☐ Chemical Dependency
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ringing
- ☐ Epilepsy
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulty
- ☐ Fatigue
- ☐ Fractures
- ☐ Goiter
- ☐ Gout
- ☐ Headache
- ☐ Heart Disease
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Irregular Heart Beat
- ☐ Kidney Disease/Infection
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraine
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Rheumatoid Arthritis
- ☐ Shortness of Breath
- ☐ Sleep Problems of Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Other (list any/all medical conditions not listed above):
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

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