PATIENT CONTACT INFORMATION

Today's Date_____

Name _____
First Name Middle Initial Last Name

What name would you like for us to call you in the clinic? _____

Name of person completing this form, if other than patient: _____

Patient's Address _____

City _____ State _____ Zip _____

Cell Phone: _____ Home Phone: _____

Birth date: _____ Age _____ Male / Female

Social Security #: _____ Driver's License #: _____

e-mail: _____

Preferred Language _____ Race _____ Ethnicity _____

Employer _____ Work Phone: _____

Employer's Address _____City _____State _____Zip _____

Occupation: _____

Marital Status: M S D W Sep Spouse:_____ Children: _____

EMERGENCY CONTACT INFORMATION

Person's Name: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address _____City _____State _____Zip _____

Your relationship to this person: _____

REFERRAL INFORMATION

Referred by: (name of person or source)_____Relationship _____

PRIMARY CARE PHYSICIAN

Your medical doctor's name: _____ Phone: _____

Address _____City _____State _____Zip _____

INSURANCE INFORMATION

Your insurance company _____ Policy/Group # _____

Primary Insured _____ Relationship _____ Date of Birth_____

HEALTH INFORMATION

PURPOSE OF THIS VISIT

Primary condition or area of pain: _____

_____

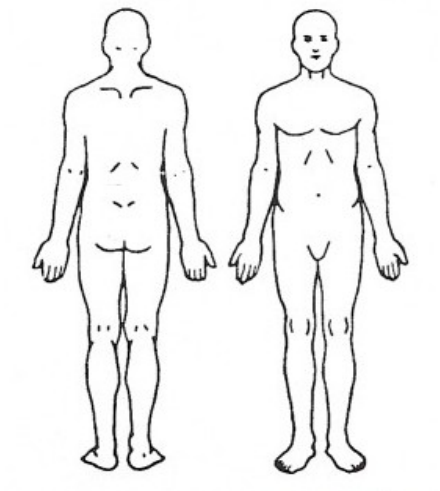
How long have you had this condition and what do you think may have caused it?

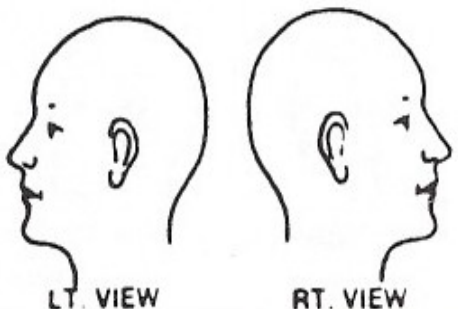
_____

_____

_____

Please use these drawings to mark the location of your symptoms. Be as accurate as possible.





PAIN SCALE

Circle either one number or a range of numbers to indicate the intensity of your pain as it is today or recently.

0 1 2 3 4 5 6 7 8 9 10

No Symptoms Worst Possible

0 = No pain at all. 1 = Almost no pain. 2 = Mild discomfort. 3 = Nagging mild pain.	4 = Bothersome pain. 5 = Pain that limits activities. 6 = Pain prevents some activities. 7 = Pain causes face expressions.	8 = Pain causes moaning/crying. 9 = Agonizing pain causes distress. 10 = Worst pain imaginable.

SEVERITY: What words describe the severity? (circle all that apply.) None. Good. Mild. Not Bad. Moderate. Discomfort. Severe. Distressing. Very Severe. Horrible. Worst Possible. Excruciating.

QUALITY: What words describe how it feels? Dull Ache. Sharp. Burning. Numbness. Tingling. _____

RADIATE: Do you have symptoms that travel remotely from the primary site of pain? _____

TIMING: When does it hurt? Constantly. Comes and goes. Morning. During the day. Night.

AGGRAVATED BY: What makes it hurt worse? Sitting. Standing. Lying. Walking. _____

RELIEVED BY: What makes it feel better? Sitting. Standing. Lying. Walking. _____

PAIN INTERFERES WITH: Work. Sleep. Daily routine. Recreation. _____

My pain is keeping me from: _____

_____

COURSE: Getting worse. Getting better. Staying the same.

TREATMENT FOR THIS CONDITION

Have you seen **another doctor** for this? __yes ___no Name: _____

Have you had **X-rays** for this? __yes __no Have you had an **MRI** for this? __yes __no

What type of **treatment** did you receive? _____

What are you doing for yourself at home? _____

Are you taking any medicines for this now? __yes __no List: _____

PAST MEDICAL HISTORY

Have you ever had a **similar** condition in the past? __yes __no If yes, please give date and brief explanation:

_____

Please list past **accidents and illnesses** with approximate dates: _____

_____

_____

Please list any **surgeries** you have had with approximate dates: _____

_____

Do you have **allergies**? __yes __no List: _____

Please list any **other medical conditions** you have, and any medications that you take: _____

_____

_____

Do you have: [ ] Hepatitis [ ] Diabetes [ ] Heart Disease [ ] HIV [ ] None of these

Have you gained or lost **weight** recently? □ No □ Gained □ Lost Please explain: _____

_____

Any **other** significant health history not already mentioned: _____

_____

SOCIAL HISTORY

Do you smoke? □ No, never □ No, I quit _____ ago □ Yes How much? _____

Drink coffee or other caffeinated beverages? □ No □ Yes _____

Drink alcohol? □ No □ Yes How much? _____

What are your hobbies and activities? _____

How much do you exercise? _____

GOALS & EXPECTATIONS (for discussion purposes)

My **goal** is to reduce my pain level to (circle one number):

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible Pain

I think I can reach my goal in: [ ] one day [ ] one week [ ] one month [ ] two months [ ] six months

I may be interested in: [ ] Acupuncture [ ] Physical Therapy [ ] Exercise Instruction

[ ] Spinal Decompression Therapy [ ] Herbal and Homeopathic Medicines

[ ] a Diet Plan [ ] Nutritional Supplements

[ ] other _____

OUR PROMISE

We, the doctor and staff members of the Bronson Clinic, will do our best to find the cause or causes of your condition, and to do our best to explain our findings in terms that you will understand. We will tell you exactly what we feel that you need, and then cheerfully provide you with the finest care available.

Following your examination and case presentation by the doctor, you will choose a care plan that fits your schedule and your budget. We want you to be so satisfied with the Bronson Clinic and our services that you will eagerly refer others to us for chiropractic care.

Is there *anything else about your health* that you want to discuss with the doctor?

Please sign _____ Date _____