DIVINE CHIROPRACTIC

PATIENT INFORMATION Today's Date: ____________

Name: ____

Age: ________ DOB: _________________ Sex: ☐ M ☐ F

Address: ____

Home: ____________ Work: ___________ Cell: _____________

Cell Carrier: _____________ e-mail: _______________________

I consent to receive appointment reminders and office

communications by text, e-mail, or telephone _______ (initials)

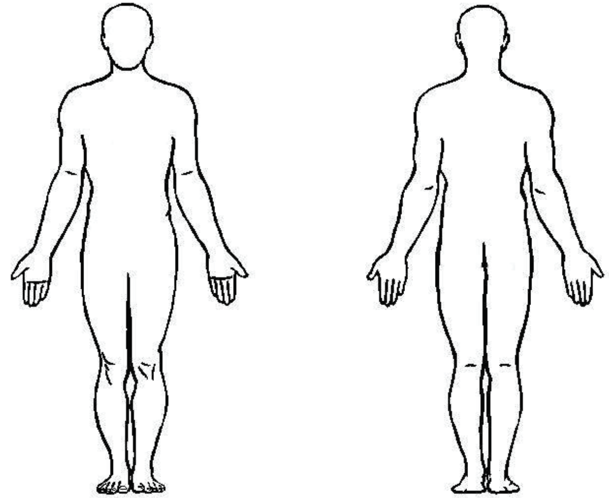
Your Employer: _______________________________________

Occupation: ____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other

Name of Spouse or Nearest Relative: _____________________

Phone Work: ___________________ Cell: __________________



Referred to this office by: ☐ Website ☐ Yellow Pages ☐ Friend/Family Member Name: ________________________

Payment for Services will be by: ☐ Cash ☐ Check ☐ Credit Card

MEDICAL/FAMILY HISTORY **S = Self M = Mother F = Father**

Please indicate which conditions have been experienced by the above by marking appropriate boxes.

S	M	F		S	M	F		S	M	F	
☐	☐	☐	anemia	☐	☐	☐	arthritis	☐	☐	☐	asthma
☐	☐	☐	back pain	☐	☐	☐	bladder trouble	☐	☐	☐	bone fracture
☐	☐	☐	cancer	☐	☐	☐	chest pain	☐	☐	☐	concussion
☐	☐	☐	convulsions	☐	☐	☐	diabetes	☐	☐	☐	indigestion
☐	☐	☐	dislocated joins	☐	☐	☐	epilepsy	☐	☐	☐	German measles
☐	☐	☐	headaches	☐	☐	☐	heart trouble	☐	☐	☐	reproductive disorders
☐	☐	☐	high blood pressure	☐	☐	☐	kidney disorder	☐	☐	☐	bowel control loss
☐	☐	☐	menstrual cramps	☐	☐	☐	multiple sclerosis	☐	☐	☐	muscular dystrophy
☐	☐	☐	neck pain	☐	☐	☐	nervousness	☐	☐	☐	numbness
☐	☐	☐	depression	☐	☐	☐	poor circulation	☐	☐	☐	hepatitis
☐	☐	☐	rheumatic fever	☐	☐	☐	rheumatism	☐	☐	☐	scarlet fever
☐	☐	☐	anxiety	☐	☐	☐	sinus trouble	☐	☐	☐	tuberculosis

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition: ____ Date of Last Physical Exam: ___________

Describe the Treatment: ____

SURGICAL HISTORY ☐ NONE

1.___________________________ Date:____________

2.___________________________ Date:____________

3.___________________________ Date:____________

ACCIDENT HISTORY ☐ NONE

☐ Job ☐ Auto ☐ Other 1. __________________ Date:__________

☐ Job ☐ Auto ☐ Other 2. __________________ Date:__________

☐ Job ☐ Auto ☐ Other 3. __________________ Date:__________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

☐ CHECK HERE IF YOU HAVE NO SYMPTOMS AND ARE HERE FOR WELLNESS CARE

Area/Body Part	Intensity	Frequency
1. ______________________	Minimal Slight Moderate Marked Severe	Intermittent Occasional Frequent Constant
2. ______________________	Minimal Slight Moderate Marked Severe	Intermittent Occasional Frequent Constant
3. ______________________	Minimal Slight Moderate Marked Severe	Intermittent Occasional Frequent Constant
4. ______________________	Minimal Slight Moderate Marked Severe	Intermittent Occasional Frequent Constant
5. ______________________	Minimal Slight Moderate Marked Severe	Intermittent Occasional Frequent Constant

If you are experiencing pain, is it: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Achy ☐ Tingling/Numb ☐ ____________________

Since the problem started, it is: ☐ About the Same ☐ Getting Better ☐ Getting Worse

Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night

Aggravated by: ☐ Sitting ☐ Standing ☐ Laying ☐ Bending ☐ Coughing ☐ Lifting ☐ Walking ☐ Turning your head

☐ Other (please describe) ____

Please list any activities you avoid or cannot do due to this condition: ____

What makes your symptoms better: ☐ Rest ☐ Ice ☐ Heat ☐ Medication __________________ ☐ Nothing

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WHEN AND HOW DID YOUR SYMPTOMS BEGIN: ____

____

☐ Gradual Onset ☐ Job Accident ☐ Car Accident ☐ Illness ☐ Unknown ☐ Other: __________________________

Have you had this problem before? ☐ Yes ☐ No When: _______________ How was it treated? _____________________

Name of doctor previously seen for this condition: ____

Have you ever been to a chiropractor before? ☐ Yes ☐ No **Was it for this problem?** ☐ Yes ☐ No

Please list all medications you are currently taking: ____

____

Are you pregnant? ☐ Yes ☐ No

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING

☐ fainting	☐ fatigue	☐ loss of balance	☐ numb fingers	☐ acid reflux	☐ numbness in toes
☐ PMS	☐ insomnia	☐ upset stomach	☐ tingling legs	☐ ear infections	☐ tingling arms
☐ constipation	☐ stiff neck	☐ shortness of breath	☐ baby with colic	☐ ringing in ears	☐ muscle jerking
☐ decreased athletic performance					

Please rate your Quality of Life 0-10: 0 1 2 3 4 5 6 7 8 9 10

The information I have provided is accurate to the best of my recollection and is intended to provide Divine Chiropractic with necessary information in order to diagnose my condition(s) and to determine the appropriate treatment. By providing this information, it is my intent to be examined, diagnosed and treated by Divine Chiropractic and for no other purpose.

Patient’s Signature: ______________________________________ Date: ______________________________

Print Name: ____