

Forth Family Chiropractic

(678) 449-5759

Patient Information

Name: _____ **Date:** _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Sex: M F Height: _____ Weight _____
Home phone: _____ Work phone: _____ Cell phone: _____
E-Mail: _____ Employer/Occupation: _____
Marital Status: S M D W Spouse's Name: _____ Ages of Children: _____
Primary Care Physician (name, address, telephone): _____
How did you hear about us? _____

Chief Complaint: Describe the major complaint that brought you to this office: _____

When did it start? _____ Have you ever had this problem before? _____
Have you seen any other doctors for this condition? Yes No Who? _____

What makes your symptoms better? Rest Motion Heat Ice Sitting Lying Other _____

What makes your symptoms worse? Standing Sitting Lying Motion Rest Bending Reaching
Coughing Sneezing Lifting Walking Other _____

Describe your pain: Dull Knifelike Burning Numb Soreness Stiffness Stabbing Sharp
Throbbing Other _____

Does it radiate to any other area of the body? Y N Where? _____

How would you describe the intensity? Mild Moderate Severe

Since the onset, is the pain: Constant Off & On Worse Better The same

Do you feel worse: In the morning In the evening Always the same

Symptoms developed from: Work-related injury Y N Auto Accident Y N Injury at home Y N
Did it begin gradually or suddenly? Gradual Sudden

What tests have been done for your condition? _____

Any X-rays in the last 2 years? Y N What area was x-rayed? _____

Have you been unable to work as a result of your current problem? _____

General Information:

Amt of sleep per night (hours): _____ Position in which you typically sleep _____

Is your sleep: Great Good Fair Poor

Are you taking any medications? (Please list) _____

Past history

Are you under a doctor's care presently for any type of health problem? _____

Have you had any broken bones? Y N Which ones? _____

Have you ever had any past significant auto accidents, work injuries or falls? Y N When? _____

Have you ever had surgery? Y N What and When? _____

Do you now or have you ever smoked, used alcohol or recreational drugs? _____

Do you have any allergies? _____

Have you been diagnosed with:

- Y N High Blood Pressure
- Y N Hardening of the arteries
- Y N Diabetes
- Y N Heart or blood vessel disease
- Y N Bone spurs on the neck
- Y N Whiplash injury
- Y N Fibromyalgia
- Y N Chronic Fatigue
- Y N Arthritis
- Y N Cancer

Type? _____

Women Only

- Y N Do you take birth control pills?
How long? _____
- Y N Menstrual pain
- Y N Irregularity
- Y N Hot Flashes
- Y N Night Sweats

Men Only:

- Y N Difficulty with urination
- Y N Excessive urination

Musculoskeletal

Neck

- () Pain in the neck
- () Neck pain with movement
- () Stiff Neck
- () Muscle spasms

Low Back

- () Low back pain
- () Sciatica
- () Muscle spasms
- () Stiffness

Shoulders

- () Pain in the shoulders (L R)
- () Pain between shoulders
- () Tension in shoulders
- () Pain with movement (L R)

Hips, Legs and Feet

- () Hip Pain
- () Pain down the leg
- () Numbness or tingling
- () Leg Cramps

Arms & Hands

- () Pain in upper arm
- () Pain in lower arm
- () Pain in wrist/hand/finger
- () Numbness or tingling in hands

- () Knee pain
- () Foot pain
- () Numbness or tingling in feet
- () Heel pain

On a scale of 1- 10 (1= None 10= Extreme) Rate the following:

_____ Personal stress _____ Occupational stress _____ Home stress

How much exercise and what types of exercise do you get each week? _____

How much water do you drink daily? _____

Are you a vegetarian? Yes No Please describe your diet and indicate whether you are on a special diet _____

I hereby certify to the best of my knowledge that the information given above is complete and correct

Patient signature _____ Date _____

Parent/Guardian signature _____ Date _____