De Jong Chiropractic and Acupuncture

Name:
(First)_____(M.I.)_____(Last)_____

Address: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____ Occupation:
_____

Date of Birth: _____ Social Security # _____-_____-_____ Gender: Male Female

Do you have Insurance? Yes No Date of birth of card holder: _____

Married__ Single__ Divorced__ Widowed___ Name of Spouse/Parent(s)
_____

Emergency Contact: _____ Phone #: _____

List any **Allergies:**
□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs □ Latex □ Molds □ Penicillin □ Ragweed/Pollen
□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other:
_____
List any **Surgeries:**
□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other:
_____

List **All Past Medical History Conditions:**
□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression □ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain □ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure □ Hip Pain □ HIV □ Jaw Pain □Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Pacemaker □ Parkinson's □ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain □ Stoke/Heart Attack □ Other: _____
List **Name** and **Type** of **Medications** you are taking:
□ Anxiety □ Muscle Relaxers □Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure □ Other: _____
_____

_____

_____

List your **Family History**:
□Arthritis □ Asthma □ Back Pain □Cancer □Depression □Diabetes □Epilepsy □Genetic Spinal Condition □ High Blood Pressure □Heart Problems □Multiple Sclerosis □Neurological Problems □ Parkinson's □

Polio □Prostate Problems □ Stroke/Heart Attack □Please List all family members who had/has any of the problems above: Example: Paternal Grandmother- High Blood Pressure

_____

_____

Have you had any auto or other accidents, Workers Compensation injuries or other significant injuries?

□ No □ Yes Describe:

_____

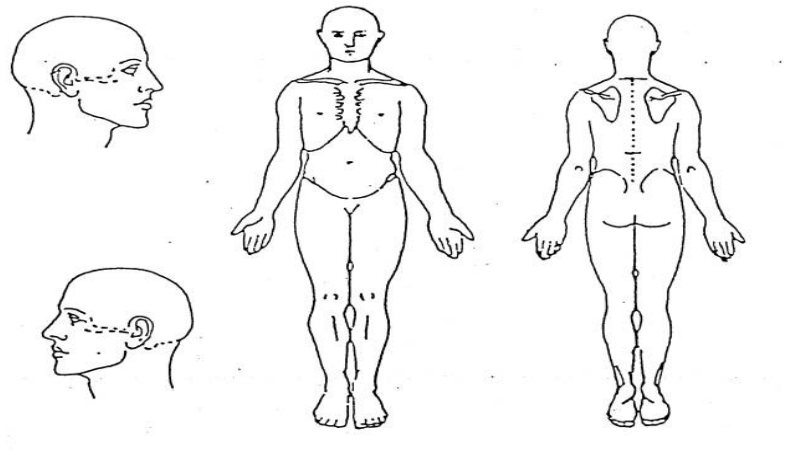
Date of last physical examination: _____ Do you smoke? □ No □ Yes

Do you drink alcohol? □ Yes □ No If yes, how often? □ Occasional □ Social □ Frequently

Do you drink caffeine? □ No □ Yes - How many per day? _____

Do you exercise? □ No □ Yes - What forms and how often? _____

If female, are you pregnant? □ No □ Yes -How many weeks? _____



*Please mark your areas of pain

What is your major complaint? _____Date problem began? _____

How did this problem begin? (falling, lifting, etc.?)

_____

How is your condition changing? □ Getting Better □ Getting Worse □ Not Changing?

Is there anything that you do that makes your condition feel better such as: □ Pain Medicine □ Ice □Heat □Other? _____

Have you had this condition in the past? □Yes □No

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Have you ever had chiropractic care? □ No □ Yes
When? _____ Why? _____
Where? _____
Were X-Rays taken? □ No □ Yes
When was your last adjustment?

Major Complaint

Please describe your major complaint and rate pain from 0-10, 10 being the worst pain and 0 being no pain. *(Ex. Sharp pain, numbness, weakness, constant pain)*

Headaches: (0-10) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □8 □ 9 □ 10
□Sharp □Dull ache □Numb □Burning □Shooting □Radiating □Throbbing
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Neck Pain: (0-10) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □8 □ 9 □ 10
□Sharp □Dull ache □Numb □Burning □Shooting □Radiating □Throbbing
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Upper Back Pain: (0-10) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □8 □ 9 □ 10
□Sharp □Dull ache □Numb □Burning □Shooting □Radiating □Throbbing
□ Constantly (76-100% of the day) □ frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Mid Back Pain: (0-10) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □8 □ 9 □ 10
□Sharp □Dull ache □Numb □Burning □Shooting □Radiating □Throbbing
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Low Back Pain: (0-10) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □8 □ 9 □ 10
□Sharp □Dull ache □Numb □Burning □Shooting □Radiating □Throbbing
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Arm Pain: (0-10) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □8 □ 9 □ 10
□Sharp □Dull ache □Numb □Burning □Shooting □Radiating □Throbbing
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Leg Pain: (0-10) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □8 □ 9 □ 10
□Sharp □Dull ache □Numb □Burning □Shooting □Radiating □Throbbing
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Patient Signature _____ Date_____

Height_____ Weight _____ BP _____/_____