ALLIED CHIROPRACTIC

1011 2nd Street North #202 • Saint Cloud, MN 56303
Phone: (320)251-6422 • Fax: (320)251-6423
AlliedStaff@AlliedChiropractic.com
www.AlliedChiropractic.com

PATIENT INFORMATION

Name: _____ DOB: ____/___/_____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Cell Carrier: _____

May we contact you via text message? [ ] Yes [ ] No

Home Phone: _____ Work Phone: _____

Email Address: _____

May we contact you via email? [ ] Yes [ ] No

Gender: [ ] Male [ ] Famle [ ] Decline Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Widowed

Emergency Contact: _____ Phone: _____

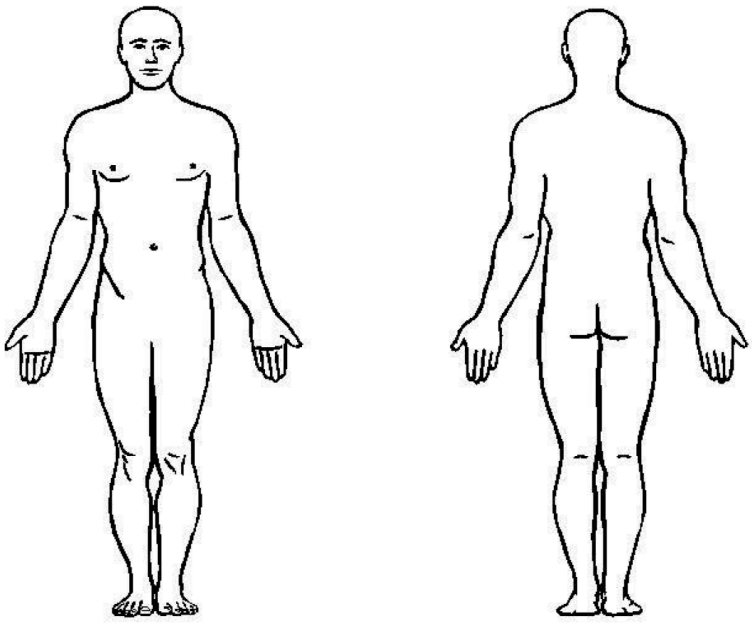
Who referred you to this office? _____ Relationship: _____

Have you had previous Chiropractic car? [ ] Yes [ ] No If yes, where? _____

Reason for consulting with this office? [ ] Pain [ ] Sports Injury [ ] Auto Accident [ ] Work Related injury

[ ] Golf Assessment [ ] Baseball/Softball Assessment [ ] Wellness Care

Other: _____



Mark the affected body parts in the illustration.

Indicate the area below along with your specific symptoms associated with each area.

1. _____
[ ] Burning [ ] Dull/Achy [ ] Sharp/Shooting [ ] Throbbing
[ ] Numbness [ ] Pins/Needles [ ] Spasm [ ] Swelling [ ] Stiff

2. _____
[ ] Burning [ ] Dull/Achy [ ] Sharp/Shooting [ ] Throbbing
[ ] Numbness [ ] Pins/Needles [ ] Spasm [ ] Swelling [ ] Stiff

3. _____
[ ] Burning [ ] Dull/Achy [ ] Sharp/Shooting [ ] Throbbing
[ ] Numbness [ ] Pins/Needles [ ] Spasm [ ] Swelling [ ] Stiff

4. _____
[ ] Burning [ ] Dull/Achy [ ] Sharp/Shooting [ ] Throbbing
[ ] Numbness [ ] Pins/Needles [ ] Spasm [ ] Swelling [ ] Stiff

How would you rate your pain on average on a scale of 0 (best) 10 (worst)? _____ At its best? _____ Worst? _____

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Date of onset (if unknown, **please estimate mm/dd/yy**): _____

What percent of the day do you have pain? [ ] 0–25% [ ] 26–50% [ ] 51–75% [ ] 76–100%

Have you had this problem in the past? [ ] Yes [ ] No

When do you feel best? [ ] Morning [ ] Afternoon [ ] Evening [ ] Night time

When do you feel worst? [ ] Morning [ ] Afternoon [ ] Evening [ ] Night time

Have you done any self treatment for this condition? [ ] Ice [ ] Heat [ ] Stretching [ ] Medications

Other: _____

Have you seen anyone else for this condition? [ ] Yes [ ] No

If yes, who? [ ] Medical Doctor [ ] Physical Therapist [ ] Chiropractor [ ] Athletic Trainer

Other: _____

What was their diagnosis? _____

Have you had any imaging of this current condition? (ie. x-rays / MRI / CT Scan) [ ] Yes [ ] No

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Have you had any recent or past injuries? (ie. auto accidents, falls, sports injury, etc): [ ] Yes [ ] No

Have you had any recent or past surgeries or hospitalizations? [ ] Yes [ ] No

Are you taking any medications? List dosage & reason for taking: _____

_____

Are you taking any supplements? List dosage & reason for taking: _____

_____

Sports/Activities/Hobbies you participate in: _____

_____

Spouse/Family/Children Activities: _____

_____

How often do you exercise? [ ] Daily (6–7 x/wk) [ ] Frequently (5–6 x/wk) [ ] Intermittently (2–3 x/wk)

[ ] Occasionally (1–2 x/wk) [ ] Never

How much do you smoke? [ ] Never [ ] 1/2 pack or less [ ] 1 pack/day [ ] 1–2 pack/day Other: _____

What position do you prefer to sleep in? [ ] Back [ ] Stomach [ ] Side lying on right [ ] Side lying on left

What is your current stress level on a scale of 0 (none) to 10 (worst)? _____

Describe your job duties: _____

How many hours a day do you sit? _____ How many hours a day do you work? _____

I have read and reviewed the information contained herein and represent that it is true, correct and complete. I understand that the doctor is relying upon this information in rendering treatment.

_____ _____

Patient Signature (Parent of Guardian if necessary) **Date**

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Review of Systems

Below are a list of conditions and diseases which may seem unrelated to your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Cardiovascular & Respiratory –
[ ] Chest Pain
[ ] Shortness of Breath
[ ] Blood Pressure Problem
[ ] Irregular Heartbeat
[ ] Heart Problems
[ ] Lung Problems/Congestion
[ ] Varicose Veins
[ ] Ankle Swelling
[ ] Stroke

Nervous System –
[ ] Anxious/Nervous
[ ] Numbness/Tingling
[ ] Paralysis
[ ] Dizziness
[ ] Forgetfulness
[ ] Convulsions
[ ] Cold/Tingling Extremities
[ ] Stress

Gastrointestinal –
[ ] Poor/Excessive Appetite
[ ] Excessive Thirst
[ ] Frequent Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Contipation
[ ] Hemorrhoids
[ ] Liver Problems
[ ] Full Bladder Problems
[ ] Abdominal Cramps
[ ] Gas/Bloating After Meals
[ ] Heartburn
[ ] Colitis
[ ] Black/Tarry Stools

Male/Female –
[ ] Menstrual Irregularity
[ ] Menstrual Cramps
[ ] Vaginal Pain/Infection
[ ] Breast Pain/Lumps
[ ] Prostate/Sexual Dysfunction
[ ] Other Problems
[ ] _____
[ ] _____

Genito-Urinary –
[ ] Bladder Trouble
[ ] Painful/Excessive Urination
[ ] Discolored Urine

Musculoskeletal –
[ ] General Stiffness
[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Neck Pain
[ ] Arm Pain
[ ] Joint Pain/Stiffness
[ ] Walking Problems
[ ] Difficulty Chewing

Ear, Nose, Throat –
[ ] Vertigo/Dizziness
[ ] Vision Problems
[ ] Dental Problems
[ ] Sore Throat
[ ] Ear Aches
[ ] Hearing Difficulty
[ ] Stuffy Nose
[ ] Dry Mouth

Female only –
When was your last period?
_____
Are you pregnant?
[ ] Yes [ ] No [ ] Unsure
Due Date: _____

General –
[ ] Fatigue
[ ] Loss of sleep
[ ] Fever
[ ] Unexplained Weight Loss or Weight Gain

Diseases/Conditions –
[ ] Pneumonia
[ ] Pleurisy
[ ] Diabetes
[ ] Anemia
[ ] Thyroid
[ ] Mumps
[ ] Polio
[ ] Epilepsy
[ ] Heart Disease
[ ] Influenza
[ ] Chicken Pox
[ ] Whooping Cough
[ ] Tuberculosis
[ ] Mental Disorders
[ ] Arthritis
[ ] Cancer
[ ] Measles

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Family Health History

Name:_____ Date: _____

Select all choices that apply to your family (do not include relations by marriage)

	Mother	Father	Siblings	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
If no longer living, please list cause of death								
Arthritis								
Cancer - type								
Depression								
Diabetes								
Headaches								
Heart Attack/ Disease								
HIgh Blood Pressure								
Multiple Sclerosis								
Osteopenia/ Osteoprosis								
Stroke								
Thyroid Disease								

I understand that the information I have provided is current and complete to the best of my knowledge.

_____

Signature (Parent or Guardian if necessary)

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