Downtown Chiropractic

421 W. Riverside Suite 711 Spokane, WA 99201

509.844.2226

Personal Information

Date _____

Full Name _____ Birth Date ___/____/_____

Age _____ Gender M F Social Security # _____ Email _____

Address _____ City _____ State ____ Zip _____

Primary Phone (_____) _____ Alt Phone (_____) _____

Employer _____ Phone Number _____

Occupation _____ How Long? _____

Marital Status _____ Spouse's Name _____ Do You Have Children? Y N How Many? _____

Whom may I thank for the referral? _____

Emergency Contact _____ Relationship _____ Phone _____

Do You Have Insurance? Yes No If yes, please fill out the information below:

Insurance Company _____ I.D. # _____

Group # (If Applicable) _____

Who is responsible for this account? _____

Relation to Patient _____

Are you covered by an additional insurance? Yes No If yes, please fill out the information below:

Insurance Company _____ I.D. # _____

Group # (If Applicable) _____

Reason for Visit

What brought you in today? Emergency New Injury Old Injury Chronic Pain Wellness

Are you in pain? Yes No **Rate your pain with the following scale:** No pain 1--2--3--4--5--6--7--8--9--10 Worst Pain

How did your injury occur? Work Sports/Play Auto Accident Routine Work Other _____

When did your injury occur? ___/___/___ **Where did your injury occur?** _____

The pain/complaints are (% of day): Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

Is your condition getting worse? Yes No Constant Comes and Goes

Is your condition interfering with your: Work Sleep Daily Routine **If so, how?** _____

Have you had similar complaints in the past? Yes No **Explain:** _____

Using the adjacent body chart, please circle all affected areas:

Does the pain radiate? Yes No **(Mark below)**

Right Upper arm Forearm Hand
Thigh Calf Foot

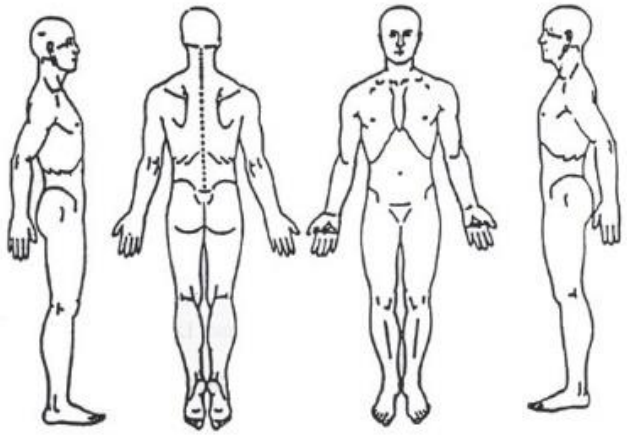
Left Upper arm Forearm Hand
Thigh Calf Foot

Type of pain?

Sharp Dull Throbbing Numbness Aching

Shooting Burning Tingling Cramps Stiffness

Swelling Other



Right Back Front Left

Please indicate pain= (xxx), numbness= (ooo), tingling= (+++), weakness= (---)

What makes the pain/complaints worse?

Bending Sitting Standing Walking Lying down Pushing/pulling with hands

Coughing Sneezing Driving Lifting Coldness Heat Reaching out/up/down

General activity Yard work Gardening Working Turning/twisting Other: _____

Past Health History

Have you been to a Chiropractor in the past? Yes No

Clinic or Doctor's name _____ **Phone #** _____

Who is your Medical Doctor? _____ **Phone #** _____

Are you taking any medication? Yes No **If so, what?** Nerve pills Pain killers (including aspirin)

Muscle relaxers Blood thinners Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Heart Attack / Stroke	Heart surg. / Pacemaker	Heart Murmur	Congenital Heart Defect
Artificial Valves	Alcohol / Drug Abuse	Venereal Disease	Hepatitis
Shingles	Cancer	Frequent Neck Pain	Glaucoma
High / Low Blood Pressure	Psychiatric Problems	Rheumatic Fever	Severe / Frequent Headaches
Ulcers / Colitis	Fainting/Seizures/Epilepsy	Sinus Problems	Emphysema / Asthma
Difficulty Breathing	Chemotherapy	Lower Back Problems	Artificial Bones/Joints/Implants
Mitral Valve Prolapse	HIV+ / AIDS	Anemia	Kidney Problems
Tuberculosis	Arthritis	Menstrual Problems	Jaw Pain
Depression	Anxiety	Dizziness	Chicken Pox
Fatigue	Hearing Problems	Diabetes	Mumps
Foot Pain	Prostate Problems	Miscarriage	Stomach Problems
Hand Pain	Tumor	Ulcer(s)	Osteoporosis
Ankle Pain	Elbow Pain	Shoulder Pain	Thyroid Problems

Please list any surgeries and/or any other serious medical condition(s) not listed above:

_____

List any past serious accidents: _____

Please list any allergies: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No **If so, what?** _____

Do you exercise? Yes No _____ hours per week

Do you smoke? Yes No **How much?** _____ **How long?** _____

Do you drink? Yes No **How much?** _____ **How long?** _____

Are you wearing: Shoe lifts Inner soles Arch supports

How often do you eat dairy? Daily Weekly Monthly Never **Do you drink caffeine?** Yes No

How often do you eat red meat? Daily Weekly Monthly Never **Are you dieting?** Yes No **Since** __/___/___

If so, what type of diet do you follow? _____

When was your last Physical Exam? __/___/___ **Were there any abnormal findings?** _____

<u>For women:</u> Are you taking Birth Control? Yes No **For how long?** _____

Are you Pregnant? Yes No **If so, how many weeks?** _____ **Are you Nursing?** Yes No