

Freedom Family Chiropractic

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Patient Demographics

1. ABOUT THE PATIENT

First Name -	Last Name -	
Birthday -	Gender ☐ Male ☐ Female ☐ Other	
Street Address -		
City -	State/Province -	Zip Code -
Cell Phone -	Home Phone -	Work Phone -
Email -	Marital Status -	Spouse's Name -
Number of children -	Children's and Ages -	Have you ever been to a chiropractor before? ☐ Yes ☐ No
Emergency Contact Name -	Emergency Contact Number -	Emergency Contact Relationship -
Who can we thank for referring you? Or how did you hear about us? -		

2. FEMALES ONLY

Are you pregnant? ☐ Yes ☐ No	Are you trying to conceive? ☐ Yes ☐ No	Are you nursing? ☐ Yes ☐ No
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3. PREGNANCY

How many weeks pregnant are you now? -	How many previous pregnancies have you had? -
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4. PREVIOUS CHIROPRACTIC CARE

When was your last adjustment?

-

Name of Previous Chiropractor(s)

-

History of Complaint(s)

5. Please identify the condition(s) that brought you to Freedom Family Chiropractic in the questions below (question #3):

If you have no conditions/problems to report please select "I don't have any problems/complaints" below.

☐ I don't have any problems/complaints ☐ I do have a problem/complaint (ex: low back pain)

6. Primary Complaint

What is your primary complaint? (Main problem/condition that you'd like help with)

-

When did the problem begin?

-

Do you feel your problem(s) is:

- ☐ Getting worse
☐ Staying the same
☐ Getting better

When is the problem at its worst?

- ☐ AM ☐ Mid-day
☐ PM ☐ Late PM

How long does it last?

- ☐ I experience it on and off during the day
☐ It comes and goes throughout the week
☐ It is constant

Is your problem the result of ANY type of accident?

☐ Yes ☐ No

If yes, what kind of accident?

-

If no, how did the problem begin?

-

Has the condition(s) ever been treated by anyone in the past?

☐ Yes ☐ No

If yes, when & by whom?

-

What kind of results did you experience?

- ☐ Helped a lot
☐ Helped a little
☐ Was no help
☐ Made it a little worse
☐ Made it way worse

What makes your symptoms better?

- ☐ Ice ☐ Heat ☐ Stretching ☐ Laying down ☐ Resting ☐ Medication
☐ Other ☐ Nothing

What makes your symptoms worse?

- ☐ Sitting ☐ Standing ☐ Walking
☐ Computer Use ☐ Bending over ☐ Lifting children/objects
☐ Exercise ☐ Other ☐ Nothing

What type of pain do you experience?

- ☐ Aching ☐ Dull ☐ Sharp/Stabbing
☐ Radiating ☐ Numbness ☐ Burning
☐ Tingling ☐ No Pain ☐ Other

Have you suffered with any of this or a similar problem in the past?

☐ Yes ☐ No

Do you have any conditions you believe may be related to your problem?

-

Any additional information you want to share with the doctor about this problem?

-

7. Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life (if other, please explain in notes):

1 = No Effect; 2 = Painful (Can Do); 3 = Painful (Limited); 4 = Unable to Perform

Carry Children/Groceries

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Lift Children/Groceries

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Sitting

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Sit to Stand

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Standing

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Walking

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Sleep

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Driving

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Read/Concentrate

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Extended Computer Use

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Exercise

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Yard Work/Shoveling

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Walk up/down Stairs

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Washing/Bathing

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Getting Dressed

☐ 1 ☐ 2 ☐ 3 ☐ 4

Notes

-

Sexual Activities ☐ 1 ☐ 2 ☐ 3 ☐ 4	Notes -
Sweeping/Vacuuming ☐ 1 ☐ 2 ☐ 3 ☐ 4	Notes -
Child/Pet Care ☐ 1 ☐ 2 ☐ 3 ☐ 4	Notes -
Dishes ☐ 1 ☐ 2 ☐ 3 ☐ 4	Notes -
Other ☐ 1 ☐ 2 ☐ 3 ☐ 4	Notes -

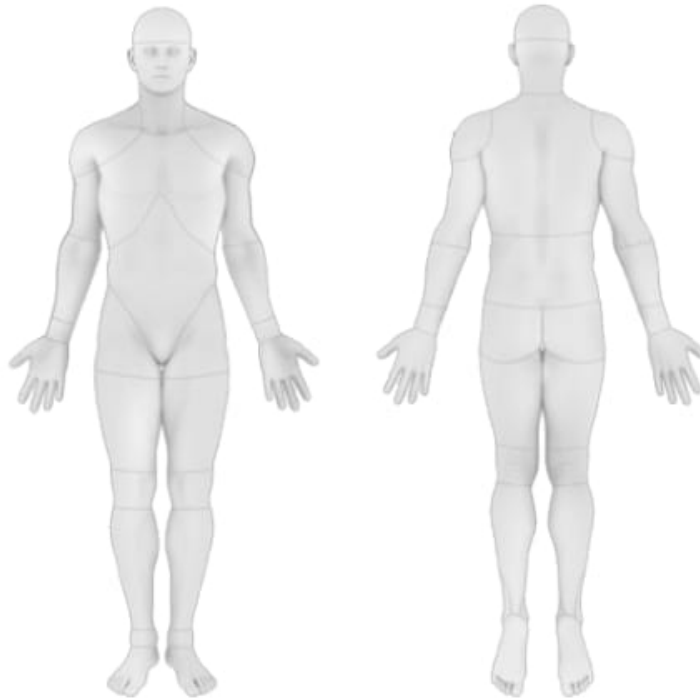
8. On a scale of 0 to 10 with 10 being the worst pain and zero being no pain, rate the severity of your PRIMARY complaint. (If pain is not a symptom you experience, rate the severity of your symptoms on the same scale)

Pain right now ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Average/typical pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Pain at its worst (most severe) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Pain at its best (least severe) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

9. Previous Episodes of Primary Complaint

When was the last episode? -	How did it happen? -	How many times has it happened in the past? -
Did you receive treatment for it? ☐ Yes ☐ No	If yes, what kind of treatment? -	
What were the results? ☐ Helped a lot ☐ Helped a little ☐ Was no help ☐ Made it a little worse ☐ Made it way worse		

10. Please mark the areas on the body diagram where you experience your symptoms:



Additional Complaints

11. Do you have any additional problems you that you would like help with?

☐ Yes ☐ No

12. Additional Problems

1. Problem

—

How long has it been an issue?

—

Constant or Occasional

—

Type of Pain

—

At its worst?

—

At its best?

—

2. Problem

—

How long has it been an issue?

—

Constant or Occasional

—

Type of Pain

—

At its worst?

—

At its best?

—

3. Problem

—

How long has it been an issue?

—

Constant or Occasional

—

Type of Pain

-

At its worst?

-

At its best?

-

13. On a scale of 0 to 10 with 10 being the worst pain and zero being no pain, rate the severity of your SECONDARY complaint. (If pain is not a symptom you experience, rate the severity of your symptoms on the same scale)

Pain right now

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ 7 ☐ 8 ☐ 9 ☐ 10

Average/typical pain

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain at its worst (most severe)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain at its best (least severe)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ 7 ☐ 8 ☐ 9 ☐ 10

Past History

14. Have you had any surgeries in the past?

☐ Yes ☐ No

Have you had any hospitalizations in the past?

☐ Yes ☐ No

Have you ever been involved in any auto collisions?

☐ Yes ☐ No

15. If yes, please list past surgeries, year of surgery, type of surgery and any important notes related to the surgery:

-

16. If yes, please list past hospitalizations, year of hospitalizations, reason for hospitalizations and any important notes related to the hospitalizations:

-

17. If yes, please list past auto collisions, year of collisions, treatment(s) received and any important notes related to the collisions:

-

18. Do you/Have you:

Have a history of weak bones (osteoporosis or osteopenia?)

☐ Y ☐ N

If Yes, Explain:

-

Have numbness/tingling or weakness in the arms/hands or legs/feet?

☐ Y ☐ N

If Yes, Explain:

-

Been diagnosed with cancer in the spine?

☐ Y ☐ N

If Yes, Explain:

-

Have an increased risk for having a stroke?

☐ Y ☐ N

If Yes, Explain:

-

Have any bone abnormality in your spine?

☐ Y ☐ N

If Yes, Explain:

-

Fractured any bone in your spine?

☐ Y ☐ N

If Yes, Explain:

-

Been diagnosed with a disc bulge or disc herniation?

☐ Y ☐ N

If Yes, Explain:

-

Had sudden numbness in the groin region or loss of bowel or urine control?

☐ Y ☐ N

If Yes, Explain:

-

Been diagnosed with Rheumatoid arthritis?

☐ Y ☐ N

If Yes, Explain:

-

19. Does anyone in your family have the following conditions?

Heart Disease

☐ Y ☐ N

If yes, whom?

-

Cancer

☐ Y ☐ N

If yes, whom?

-

Diabetes

☐ Y ☐ N

If yes, whom?

-

Rheumatoid Arthritis

☐ Y ☐ N

If yes, whom?

-

Social History

20. Do you:

N = Never; Y = Yes; P = Past

Smoke

☐ N ☐ Y ☐ P

Frequency

-

Drink alcohol

☐ N ☐ Y ☐ P

Frequency

-

Take pain medication

☐ N ☐ Y ☐ P

Frequency

-

Use recreational drugs

☐ N ☐ Y ☐ P

Frequency

-

Exercise

☐ N ☐ Y ☐ P

Frequency

-

Medications

Do you currently take any medications or supplements, including any over-the-counter medications, herbs or vitamins?

☐ Yes ☐ No

22. List all medications you are taking, including any over-the-counter medications, herbs or vitamins: (Please include name, dosage, frequency and reason for taking)

-

23. Are you taking any:

Blood thinning medication?

☐ Yes ☐ No

Steroid medication?

☐ Yes ☐ No

Review of Systems

24. Please indicate if any of these problems apply to you and if they are Current, Past, or Occasional problems. **LEAVE BLANK IF IT HAS NEVER BEEN A PROBLEM FOR YOU.**

C = Current; P = Past; O = Occasional

Headaches

☐ C ☐ P ☐ O

Migraines

☐ C ☐ P ☐ O

Dizziness

☐ C ☐ P ☐ O

Vertigo

☐ C ☐ P ☐ O

Balance

☐ C ☐ P ☐ O

Fatigue

☐ C ☐ P ☐ O

Trouble Sleeping

☐ C ☐ P ☐ O

Nausea/Vomiting

☐ C ☐ P ☐ O

Shortness of Breath

☐ C ☐ P ☐ O

Asthma

☐ C ☐ P ☐ O

Lung Problems

☐ C ☐ P ☐ O

Chest Pains

☐ C ☐ P ☐ O

Heart Problems

☐ C ☐ P ☐ O

Heart Pacemaker

☐ C ☐ P ☐ O

High Blood Pressure

☐ C ☐ P ☐ O

Low Blood Pressure

☐ C ☐ P ☐ O

Fainting

☐ C ☐ P ☐ O

Stroke History

☐ C ☐ P ☐ O

Convulsions/Epilepsy

☐ C ☐ P ☐ O

Diabetes

☐ C ☐ P ☐ O

Cancer

☐ C ☐ P ☐ O

Numb/Tingling arms, hands, fingers

☐ C ☐ P ☐ O

Numb/Tingling legs, feet, toes

☐ C ☐ P ☐ O

Neck Pain

☐ C ☐ P ☐ O

Mid Back Pain

☐ C ☐ P ☐ O

Low Back Pain

☐ C ☐ P ☐ O

Hip Pain

☐ C ☐ P ☐ O

Joint Pain/Swelling

☐ C ☐ P ☐ O

Easy Bruising

☐ C ☐ P ☐ O

Blurred or Double Vision

☐ C ☐ P ☐ O

Ringing in Ears

☐ C ☐ P ☐ O

Hearing Loss

☐ C ☐ P ☐ O

Heartburn

☐ C ☐ P ☐ O

Digestive Problems

☐ C ☐ P ☐ O

Kidney Problems

☐ C ☐ P ☐ O

Liver Problems

☐ C ☐ P ☐ O

Liver Problems ☐ C ☐ P ☐ O	Fibromyalgia ☐ C ☐ P ☐ O	ADD/ADHD ☐ C ☐ P ☐ O
Mood Changes ☐ C ☐ P ☐ O	Depression ☐ C ☐ P ☐ O	Anxiety ☐ C ☐ P ☐ O
Cold Hands/Feet ☐ C ☐ P ☐ O	Menstrual Problems ☐ C ☐ P ☐ O	Prostate Problems ☐ C ☐ P ☐ O
Jaw Pain/TMJ ☐ C ☐ P ☐ O	Tension/Irritability ☐ C ☐ P ☐ O	Allergies ☐ C ☐ P ☐ O

I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Freedom Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize payment to be made directly to Freedom Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Freedom Family Chiropractic for any and all services I receive at this office.

Signature	Date Signed
Printed Name	Email