

# SpinalCare Center

## Patient Information

Date: \_\_\_\_\_ Patient # \_\_\_\_\_  
Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: M S W D  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Spouse's Birth Date: \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

Have you ever been under Chiropractic care? \_\_\_\_\_ When? \_\_\_\_\_  
Name of Chiropractor: \_\_\_\_\_  
How were you referred to our office? \_\_\_\_\_  
Date and description of any surgeries: \_\_\_\_\_

### HISTORY OF PRESENT ILLNESS:

If this is due to an accident, please describe: \_\_\_\_\_  
Date of last MRI or CAT scan: \_\_\_\_\_  
What medications or drugs are you taking? \_\_\_\_\_

### Terms of Acceptance

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICAL OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations and necessary therapies to assist in that goal.

I, \_\_\_\_\_, have read and fully understand the above statements.  
Print Name

[ ] I accept chiropractic care on this basis.  
[ ] I authorize care for my son/daughter \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# SUMMARY

1. What is your reason for coming to our office? \_\_\_\_\_
2. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_  
How did it originally occur? \_\_\_\_\_  
Has it become worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually Worse \_\_\_  
If yes, when and how? \_\_\_\_\_
3. How frequent is the condition? Constant \_\_\_ Daily \_\_\_ Intermittent \_\_\_ Night Only \_\_\_  
How long does it last? All Day \_\_\_ Few Hours \_\_\_ Minutes \_\_\_\_\_
4. Are there any other conditions or symptoms that may be related to your major problem?  
Yes \_\_\_ No \_\_\_\_\_. If yes, describe: \_\_\_\_\_  
Are there other health problems? Yes \_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
5. Describe the pain: Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_  
Burning \_\_\_ Stabbing \_\_\_ Other \_\_\_\_\_
6. Is there anything you can do to relieve the problem? Yes \_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_. If no, what have you tried to do that has not helped? \_\_\_\_\_  
\_\_\_\_\_
7. What makes the problem worse? Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending \_\_\_  
Lifting \_\_\_ Twisting \_\_\_ Other \_\_\_\_\_
8. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_  
\_\_\_\_\_
9. Is your problem affecting your  
\_\_\_\_ daily activities, if so which ones \_\_\_\_\_  
\_\_\_\_ Spousal or family relationships \_\_\_\_\_ Sleep  
\_\_\_\_ Sports/ recreation \_\_\_\_\_ Energy level  
\_\_\_\_ Concentration \_\_\_\_\_ Memory  
Please place a "X" next to all that apply on the above question
10. How committed/ motivated are you to getting well, 0-10? \_\_\_\_\_  

NO	EXTREME
SYMPTOMS	SYMPTOMS
0	10

Please place an "X" on the line above to indicate level of problem.
11. **WOMEN ONLY:** Are you pregnant or is there any possibility you may be pregnant?  
Yes \_\_\_ No \_\_\_ Uncertain \_\_\_\_\_

-----**DO NOT WRITE BELOW THIS LINE!!!!!!!!!!!!!!**-----

DOCTOR'S CONSULT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_