



Patient Introduction

General Information

Today's Date _____

Patient name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Patient Sex: *M F* Marital Status: *S M W D* Number of Children _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Patient E-Mail Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Primary Doctor Name: _____ Phone: _____ Last Seen: _____

Have you ever seen a chiropractor before? YES/NO

If you answered YES, when was your last visit? _____

Have you ever had an acupuncture treatment? YES/NO

If you answered YES, when was your last visit? _____

How did you find out about our office? _____

Are you or have you ever been a member of Eastpointe health and fitness (GYM)?

YES or NO

PLEASE TURN OVER

Health History

Describe your current complaint: _____

Have you ever had prior treatment for this issue? _____

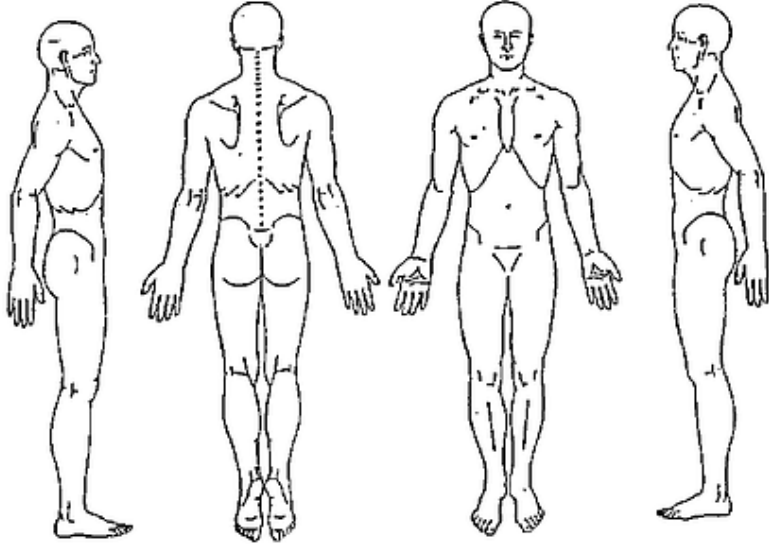
How did it begin? _____

How long have you had it? _____

Please rate your pain level: _____

0
1
2
3
4
5
6
7
8
9
10
(no pain)
(moderate pain)
(terrible pain)

Please shade the areas where you feel pain.



Below is a listing of symptoms, conditions or habits.

Please check all that apply:

Symptoms	Past	Present	Symptom	Past	Present	Symptom	Past	Present
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Arm/elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine use	<input type="checkbox"/>	<input type="checkbox"/>
Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problem	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	Please List _____		
Pain in upper leg or hip	<input type="checkbox"/>	<input type="checkbox"/>	Breast soreness/lumps	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Pain in lower leg or knee	<input type="checkbox"/>	<input type="checkbox"/>	Sinus condition	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Pain in ankle or foot	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Swelling/stiffness of joints	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Excessive weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		
General prolonge fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Prostate condition	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Condition of uterus/ovaries	<input type="checkbox"/>	<input type="checkbox"/>						