LYKENS
CHIROPRACTIC, INC.
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540.667.7388 • www.lykenschiropractic.com

Appt: Client #

PATIENT INFORMATION

Name_____ Date _____ Referred by_____
First MI Last

Address_____ City/State/Zip_____

Phone # _____ Cell # _____ Email Address _____

Social Security #_____ Birth Date _____ Gender: Male___ Female___

Weight _____ Height ____' ____" Preferred Language _____

Insurance Carrier _____ Insurance ID# _____

Insurance Subscriber _____ Subscribers Date of Birth _____

Relationship to Subscriber _____

CMS requires providers to report both race and ethnicity:

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Marital Status: married___ divorced___ single___ separated___ widowed___ Number of children_____

Current Employer_____ Occupation_____

Employer Address (if known) _____ Work Phone # _____

FEMALE PATIENTS RECEIVING X-RAYS

Here at LYKENS CHIROPRACTIC, Inc., we want to ensure that each and every patient receives the safest care possible. If by chance you are pregnant, it is important that we protect you from any unnecessary radiation that could affect the development of an unborn child in uterus.

Is there a chance that you may be pregnant at this time? ___YES ___NO Date of last menses_____

By signing your name below, you deny pregnancy at this time and give permission to proceed with your X-ray if needed.

*Signature*_____ *Date*_____

PURPOSE FOR TODAY'S APPOINTMENT

*(Please **X** all that apply)*

Maintaining a healthy lifestyle_____ Enhancing athletic performance_____ Prevention of illnesses_____
Relief for a specific injury or condition_____ Improving your overall health without drugs or surgery_____

Please list below the main complaints you have in order of their importance.

1._____ How long? _____
2._____ How long? _____
3._____ How long? _____
4._____ How long? _____

What caused today's problem? *(give date if known)* _____
Have you experienced this problem in the past? ___Yes ___No If so, when? _____
Describe your pain or discomfort *(dull, sharp, burning, tingling, pins & needles, stabbing, numb, etc)* _____
_____
Does this problem stay in one area or travel somewhere else? _____
Are you experiencing any restrictions in your range of motion? If yes, which joints? _____
What makes it better? *(sitting, standing, walking, lying down, etc)*_____
What makes it worse? _____
Have you seen anyone else for this condition and when? _____
Have you taken anything for this condition since it began or tried something to help your problem? (i*f yes, explain)*
_____
Have you had an MRI or any other imaging of the spine done? YES/NO If yes, when and where _____
_____
How has this affected your daily activities? _____

HEALTH CARE HISTORY

Do you regularly consult any of the following care providers? (check all that apply)
___Medical Physician ___Naturopath ___Acupuncturist ___Homeopath ___Psychotherapist ___Dentist
Name and reason why: _____
_____
Date of last medical examination_____ Were there any complications? _____
Have you been to a Chiropractor before? YES / NO Date of last adjustment_____ Chiropractor_____
Reason for previous chiropractic care_____
How often did you go? ___Regular monthly check-ups ___Bi-weekly ___Weekly ___Only when needed
Why did you discontinue care?_____
Are you or have been treated by a Physical Therapist? YES/NO How often are you being seen? _____
Have you ever had a professional massage before? YES/NO If yes, when was your last visit: _____
Do you have a pressure preference with massage? ___ Light Pressure ___ Medium Pressure ___ Deep Pressure
Are you sensitive to fragrances, perfumes, or nut oils? YES/NO If yes, please explain _____

PAST HISTORY

Have you had any accidents related to any of the following? (check all that apply)
___Automobile ___Motorcycle ___Bicycle ___Sports ___Playground ___Abuse
If yes, please explain how and dates: _____
_____
Have you ever injured your spine (head, neck, rib/chest area, back, pelvis, or hips)? ___Yes ___No
If yes, please explain how and dates: _____
Have you ever been hospitalized? ___Yes ___No If yes, please explain why and for how long: _____
_____
List any other injuries or accidents & dates_____
List any surgeries & dates_____
List anything that you have been diagnosed with *(past or current)* _____

(PLEASE FILL OUT BACK OF FORM)

PAST HISTORY CONTINUED

Do you have a family history of ___arthritis ___cancer ___diabetes ___heart disease ___scoliosis?
Do you or have you ever used tobacco products? YES / NO If yes, former smoker___ current smoker___ #___per day
If yes, what year started _____ and/or what year stopped _____
Have you been exposed to any of the following on a regular basis, (past or present)?
___Toxic chemicals ___Drugs (prescribed or not) ___Second hand smoke ___Other
If yes, please explain: _____
Prescription and non-prescription medication may cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. Are you currently taking any medications? (Include regularly used over the counter medications)

Medication Name	Treating	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

What vitamins or other nutritional supplements do you take? _____
How often do you consume the following? Coffee/caffeine #___ per week Alcohol #___ per week Diet soda #___per week
Do you exercise? YES / NO How often and what activities? _____
How many servings of **RAW** fruits and vegetables do you consume per day? _____
Do you get sufficient sleep at night? YES/NO _____
How much water do you drink throughout the day? _____

PAST & PRESENT CONDITIONS

(Please X all that apply)

___Neck pain (right/left)
___Headaches
___Numbness in arms, hands, fingers
___Ear Infections
___Frequent Colds or Flu
___Allergies/Sinus Problems
___Loss of Taste or Smell
___Dizziness
___Blurred or Doubled Vision
___Convulsion/Epilepsy
___Stroke, Date _____
___Pass Out
___Trouble Concentrating
___Trouble Sleeping
___Nervousness/Anxiety
___Mental/Emotional Disorders:_____
___ Jaw Pain/Clenching

___Asthma/Difficulty Breathing
___Shoulder Pain (right/left)
___Chest Pain
___Heart Problems
___High/Low Blood Pressure
___Digestive Problems/Heartburn
___Ulcers
___Gall Bladder Problems
___Mid-Back Pain/Stiffness
___Hip Pain (right/left)
___Numbness in legs, feet, toes
___Knee Pain (right/left)
___Kidney Troubles
___Frequent/Difficulty Urination
___Diarrhea/Constipation
___Colon Trouble
___Hemorrhoids

___Excessive Gas
___Liver Problems
___PMS/Menstrual Problems
___Impotence
___Prostate Problems
___Hernias
___Blood Clots
___Varicose Veins
___Arthritis/Tendonitis
___Swollen/Painful Joints
___Joint Replacements: _____
___Fractured Bones: _____
___Muscle Spasms
___Fibromyalgia
___Cancer/Tumors
___Abnormal skin condition
___Contagious or Infectious Diseases

QUALITY OF LIFE

How do you grade your physical health?	___Good	___Fair	___Poor
How do you grade your emotional/mental health?	___Good	___Fair	___Poor
How do you rate your overall "quality of life"?	___Good	___Fair	___Poor
How do you rate your current diet/nutritional state?	___Good	___Fair	___Poor
How do you rate your level of negative stress?	___High	___Moderate	___Low

Patient Signature_____ **Date**_____