Armstrong CHIROPRACTIC

Date : ______________________

PATIENT INFORMATION

Last Name: ______________________ First: ______________________ Middle: ______________ Sex: ☐M ☐F

Address: ______________________ City: ______________________ State: _______ Zip: ______________

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________

Date of Birth: __________________ Age: ____ Social Security #: ________________ Email: ______________________

Marital Status: ☐Single ☐ Married ☐Widowed ☐Partnered ☐Divorced ☐Minor

Occupation: ______________________ Who Referred you to our office? ______________________

Employer's Name & Address: ______________________

Spouse's name: ______________________ Spouse's Employer: ______________________

Primary Care Physician: ______________________ Phone #: ______________________

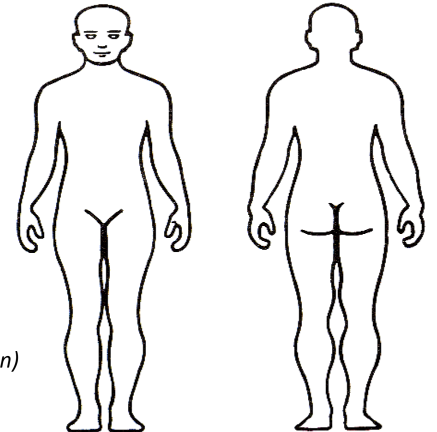
Emergency Contact Name: ______________________ Relationship : ______________ Phone #: ______________

PATIENT CONDITION *(Mark an **X** on the picture below where you are experiencing pain)*

Reason for the visit: ______________________

When did your symptoms appear and how? ______________________

Is this condition getting worse? ☐ Yes ☐ No



Type of pain: ☐ Aching ☐ Burning ☐ Stabbing ☐ Spasm

☐ Pins & Needles ☐ Throbbing ☐ Stiff ☐ Sore

Does the pain radiate or travel to any areas of your body? ☐ Yes ☐ No

If yes, where? ______________________

Do you have any numbness or tingling? ☐ Yes ☐ No

If yes, where? ______________________

Rate severity of pain: *(no pain)* 0 1 2 3 4 5 6 7 8 9 10 *(severe pain)*

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

How often do you have pain? ______________________ ☐ Constant ☐ Come and Go ☐ Frequent ☐ Occasional

Activities that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Getting up & down

Does anything make the problem worse? ______________________

Does anything make the problem better? ______________________

What treatment have you received for your current condition? ☐Medication ☐Surgery ☐Chiropractic ☐Physical Therapy ☐None

☐Other: ______________________

ACCIDENT INFORMATION: Is condition due to an accident? ☐ Yes ☐ No Date: ______________________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other ______________________

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker's Comp ☐ Other ______________

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MEDICAL HISTORY

Date of last: *Physical Exam* ________________ *Spinal X-Ray* __________________ *Blood Test* ______________________

Bone Scan ___________________ *Chest X-Ray* ___________________ *MRI/CT Scan* ____________________

Please check to indicate if you have or have had any of the following:

☐ AIDS/HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Brest Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Chronic Fatigue
☐ Concussion
☐ Diabetes
☐ Digestive Problems
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Fibromyalgia
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Headaches
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraines
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sinus Trouble
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infection
☐ Other __________
____

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking
☐ Alcohol
☐Coffee/Caffeine Drinks
☐ High Stress Level

Packs per day ___________
Drinks per week __________
Cups per day ____________
Reason ________________

Allergies: ____

Medications:
____
____

Vitamins / Herbs / Minerals:
____
____

Injuries:	Description	Date
Falls	______________________	__________
Broken Bones	______________________	__________
Surgeries	______________________	__________
Dislocations	______________________	__________
Major Injuries	______________________	__________

FEMALES ONLY: Are you pregnant or any possibility you may be pregnant? ☐Yes ☐No Due Date: ____________________

2014 Birdcreek Terrace • Temple, Texas 76502
Tel 254.778.5575 • www.armstrongchiropractic.com