COLEMAN FAMILY CHIROPRACTIC ~ THE PG WELLNESS INSTITUTE
~ NATURAL HEALING FOR A LIFETIME OF WELLNESS ~
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WELCOME

Thank you for choosing our practice for your chiropractic and wellness needs. Please complete this form in ink.
If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to assist you!

Patient Information Today's Date: ______________

Name: ______________ Birthdate: ______________

Address: ______________ City/State/Zipcode: ______________

Primary Phone: ______________ Work Phone: ______________

E-Mail Address: ______________

Employer: ______________ Occupation: ______________

Spouse's/Parent's Name: ______________ Employment: ______________

Who may we thank for referring you to us? ______________

Do you have any health problem(s) that concern you? ______________

____

When did you first notice the symptom(s)? ________ Is this condition getting progressively worse? Y N

Where specifically is the problem(s) located? ______________

____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Lying Down
☐ Walking ☐ Running ☐ Jumping ☐ Bending ☐ Other: ______________

What type of pain are your experiencing? ☐ Aching ☐ Burning ☐ Cramps ☐ Dull
☐ Numbness ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Tingling ☐ Throbbing

Please rate the severity of your pain (1 = mild; 10 = severe): 1 2 3 4 5 6 7 8 9 10

Is this pain constant or does it come and go? ______________

What type of treatment have you already received for your condition?
☐ Medication ☐ Physical Therapy ☐ Surgery ☐ Other: ______________

Name and address of the other physicians and therapist who have treated you for your condition:

Name: ______________ Name: ______________ Name: ______________

City: ______________ City: ______________ City: ______________

Patient File #: ________

General History

Please circle 'C' for current symptoms and 'P' for past symptoms you have experienced

Please check off any of the following symptoms you have experienced in the past six (6) months:

C P Headaches/Tension
C P Fatigue/Tired
C P Ringing in Ears
C P Pain/Tension/Numbness
- ☐ Neck ☐ Arms
- ☐ Shoulders ☐ Hands
- ☐ Upper Back ☐ Legs
- ☐ Lower Back ☐ Feet

C P Allergies/Sinus Problems
C P Weight Trouble
C P Digestive/Bladder Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating
- ☐ Gas
- ☐ Heartburn

C P Asthma
C P Dizziness
C P Irritability
C P Menstrual Problems
C P Nervousness
C P Insomnia/Sleep Problems
C P Other ______
C P Other ______

How are the symptoms causing you to be?

☐ Moody ☐ Irritable ☐ Restricted in Daily Activities ☐ Interrupted Sleep

How does the symptoms affect your work?

☐ Decision Making ☐ Attitude ☐ Productivity ☐ Long Hours ☐ End of the Day

How are the symptoms affecting your life?

☐ Level of Patience ☐ Limited Duties ☐ Exercise/Sports ☐ Hobbies

Dates of last medical exam: ______

[Women] Are you pregnant? Y N Are you Nursing? Y N Are you taking Birth Control Pills? Y N

Please list any type of surgeries you have had and the dates when they occurred:

______

______

Please list all medications you are currently taking:

______ ______ ______

______ ______ ______

What supplements do you currently take?

______ ______ ______

______ ______ ______

Allergies: ______

Daily Habits

What is your daily activity level? ☐ Little to No Activity ☐ Moderate Activity ☐ Heavy Activity

What do your daily work habits include?

______ ______ ______

______ ______ ______

About how much caffeinated beverages do you consume on a daily basis? ______

Do you smoke? ☐ Yes ☐ No If yes, how much do you smoke per day? ______

About how much liquor do you consume on a weekly basis? ______

I certify I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Coleman Family Chiropractic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Coleman Family Chiropractic or chiropractic group insurance benefits otherwise payable to me. I understand my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent if minor): ______ Date: ______

Patient File #: ______