CROMSHAW CHIROPRACTIC CENTER

PATIENT INFORMATION

Date: _____ Patient #_____

Name: _____
Last Name First Middle

Address: _____

City: _____State: _____ Zip _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ E-mail: _____

Birth Date: _____ Sex: ☐ Male ☐ Female

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

SS#: _____

☐ Employed ☐ Student ☐ Retired ☐ Homemaker

Occupation: _____

Employer/School _____

Address: _____

Spouse's Name: _____

Spouse's Birth date: _____

CHIROPRACTIC EXPERIENCE

Who referred you to our office? _____

☐ Sign ☐ Yellow pages ☐ Website ☐ Google

Have you see a Chiropractor before? ☐ yes ☐ no

Name of Chiropractor_____ Date of last visit: _____

EMERGENCY CONTACT

Name: _____Relationship: _____

Cell: _____ Home: _____

REASON FOR THIS VISIT

The condition that brought you in today_____

When did this problem begin: _____

Have you had this condition before? ☐ Yes ☐ No

Explain: _____

INSURANCE

Who is responsible for this account?

_____

Relationship to Patient _____

Insurance Co. _____

ID # _____ Group # _____

Is there a Secondary Insurance ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate: _____

ACCIDENT INFORMATION

Is condition due to an accident: ☐ Yes ☐ No'

Accident Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Slip/Fall

HEALTH HABITS

☐ Smoking: Packs/Day _____ Packs/Week _____

☐ Alcohol: Drinks/Day _____ Drinks/Week _____

☐ Coffee/Caffeine/Soda: Cups/Day _____

☐ High Stress Level Reason: _____

MEDICATIONS

☐ Stimulants ☐ Cholesterol Medication
☐ Tranquilizers ☐ Blood Pressure Medicine
☐ Insulin ☐ Pain Killers
☐ Muscle Relaxers ☐ Other _____

SUPPLEMENTS

☐ Essential Fatty Acids ☐ Calcium/Magnesium
☐ Vitamin C ☐ Probiotics
☐ Multivitamin which _____
☐ Other _____

ALLERGIES

_____

_____

SURGERIES

_____

_____

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have or have had any of the following: While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Depression/Anxiety	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	AIDS/HIV	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Low Back Pain	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Lyme Disease	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Bladder infection	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No	Prostate Problems	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Eating disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Sinus Problem	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ N0

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No

If yes, when Is your due date?

_____

Are you Nursing? ☐ Yes ☐ No

Are you taking Birth Control?
☐ Yes ☐ No

DO YOU:

Experience painful periods? ☐ Yes ☐ No
Have irregular cycles? ☐ Yes ☐ No
Have Breast Implants? ☐ Yes ☐ No

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

_____ _____ _____

Printed Name Signature Date

Many problems and health concerns can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

ARE YOU AWARE THAT

Doctors of Chiropractic work with the nervous system
☐ YES ☐ NO

The Nervous system controls all bodily functions and systems.
☐ YES ☐ NO

Chiropractic is the largest natural healing profession in the world.
☐ YES ☐ NO

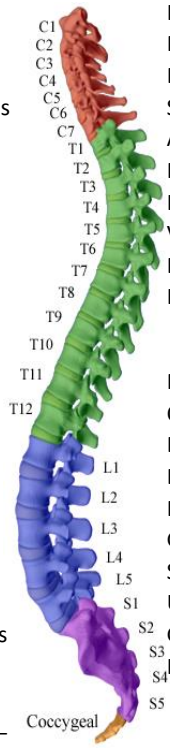
GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Dr. Cromshaw will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care: Symptomatic relief of pain or discomfort.
☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.
☐ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
☐ I want Dr. Cromshaw to select the type of care for my condition.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

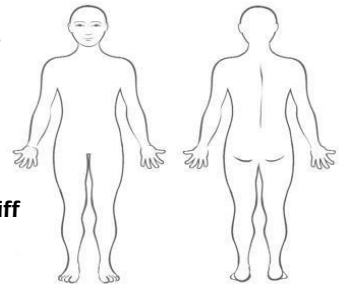
Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problem
Low Back Pain
Pain or Numbness in legs
Reproductive Problems
OTHER:
_____
_____



Headaches
Migraines
Dizziness
Sinus Problem
Allergies
Fatigue
Head Cold
Vision Problems
Difficulty Concentrating
Hearing Problems

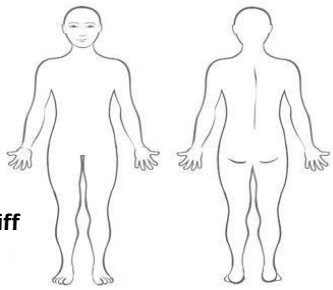
Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Condition
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Mark an "X" on the picture where you continue to have discomfort / pain / symptoms for EACH complaint



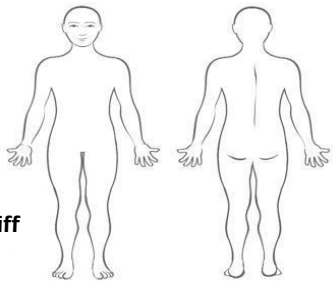
Your chief complaint: _____ Symptoms first appeared? _____

Condition is ☐ Getting Worse ☐ staying same ☐ Comes & goes ☐ Unbearable
Rate the severity of your discomfort on a scale of 0 to 10 with 10 being the worst.
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Is condition: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Pain your experiencing? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Ache ☐S hooting ☐ Tingling ☐ Numbness ☐ Stiff
Does it interfere with you're ☐ Work ☐ Sleep ☐ Daily Routine
Is pain radiating: ☐ Yes ☐ NO IF YES WHERE? ☐ R. Arm ☐ L. Arm ☐ R. Leg ☐ L. Leg



Secondary complaint: _____ Symptoms first appeared? _____

Condition is ☐ Getting Worse ☐ staying same ☐ Comes & goes ☐ Unbearable
Rate the severity of your discomfort on a scale of 0 to 10 with 10 being the worst.
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Is condition: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Pain your experiencing? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Ache ☐ Shooting ☐ Tingling ☐ Numbness ☐ Stiff
Does it interfere with you're ☐ Work ☐ Sleep ☐ Daily Routine
Is pain radiating: ☐ Yes ☐ NO IF YES WHERE? ☐ R. Arm ☐ L. Arm ☐ R. Leg ☐ L. Leg



Additional complaint: _____ Symptoms first appeared? _____

Condition is ☐ Getting Worse ☐ staying same ☐ Comes & goes ☐ Unbearable
Rate the severity of your discomfort on a scale of 0 to 10 with 10 being the worst.
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Is condition: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Pain your experiencing? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Ache ☐ Shooting ☐ Tingling ☐ Numbness ☐ Stiff
Does it interfere with you're ☐ Work ☐ Sleep ☐ Daily Routine
Is pain radiating: ☐ Yes ☐ NO IF YES WHERE? ☐ R. Arm ☐ L. Arm ☐ R. Leg ☐ L. Leg

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health

Printed Name _____ Signature _____ Date of Birth _____ Date _____