Greater Cincinnati Chiropractic

Patient Information:

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ○ Male ○ Female Height: _____ Weight: _____

Married/Single: _____ Spouse Name: _____ Email: _____

Home # _____ Cell # _____ Work # _____

Text Appointment Reminders: ○ Yes ○ No (If you choose yes, one text message will be sent to you the day of your appointment)

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Emergency Relation _____ Emergency Phone _____

Employer Information:

Employed: ○ Yes ○ No Retired: ○ Yes ○ No Employer Name: _____

Occupation: _____ Work Duties: _____

Referral Information:

Did someone refer you to our office?

Referring Physician: _____ Referring Patient: _____ Other: _____

How did you hear about us?

○ Google ○ Facebook ○ Yahoo ○ Health Grades ○ Chiropractor Near Me

○ Sign ○ Drive By ○ Yellow Pages ○ Mailing ○ Other _____

Chiropractic Experience:

Have you ever been seen by a Chiropractor? ○ Yes ○ No If yes, Why? _____

Doctor's Name: _____ Approximate Date of Last Visit: _____

Reason for this Visit:

Describe the reason for your visit?

When did this concern begin? _____ **Injury Occurred:** O **Work** O **Automobile** O **Other**_____

Has this concern occurred before? O **Yes** O **No** **Explain:** _____

Have you seen other doctors for this concern? O **Yes** O **No** **Doctor's Name:** _____

Type of Treatment: _____

Where is your Pain/Discomfort?

O **Neck**	O **Upper Back**	O **Mid Back**	O **Lower Back**
O **Right Shoulder**	O **Right Arm**	O **Right Elbow**	O **Right Hand**
O **Left Shoulder**	O **Left Arm**	O **Left Elbow**	O **Left Hand**
O **Right Thigh**	O **Right Knee**	O **Right Leg**	O **Right Foot**
O **Left Thigh**	O **Left Knee**	O **Left Leg**	O **Left Foot**

On a scale from 1 to 10, what would you rate your pain right now? O **1** O **2** O **3** O **4** O **5** O **6** O **7** O **8** O **9** O **10**

How much of the day is the pain/discomfort present? O **25% of the day** O **50% of the day** O **75% of the day** O **100% of the day**

On a scale from 1 to 10, rate your worst pain/discomfort during this episode: O **1** O **2** O **3** O **4** O **5** O **6** O **7** O **8** O **9** O **10**

On a scale from 1 to 10, rate your least pain/discomfort during this episode: O **1** O **2** O **3** O **4** O **5** O **6** O **7** O **8** O **9** O **10**

Did this pain or discomfort begin: O **Suddenly** O **Gradually**

Since the pain or discomfort has begun, has it gotten: O **Worse** O **Better** O **Same**

What aggravates this?

O **Working**	O **Lifting**	O **Walking**	O **Running**
O **Driving**	O **Sitting**	O **Standing**	O **Bending**
O **Kneeling**	O **Changing Positions**	O **Dressing**	O **Exercising**
O **Sleeping**	O **Turning/Twisting**	O **Reaching**	O **Using Computer**

O **Other** _____

What relieves this pain or discomfort?

O **Nothing**	O **Rest**	O **Sleeping**	O **Sitting**
O **Walking**	O **Standing**	O **Stretching**	O **Aspirin**
O **Acetaminophen (Tylenol)**	O **Ibuprofen (Motrin)**	O **Ice**	O **Heat**
O **Biofreeze/Icy Hot**	O **Other** _____		

Reason for this Visit (continued):

How would you describe your pain/discomfort?

O Mild	O Moderate	O Severe
O Aching	O Burning	O Dull
O Numbness	O Sharp	O Throbbing
O Tingling	O Stiff	O Other _____

When is the pain or discomfort the worst?

O Morning	O Afternoon	O Evening

Does the pain or discomfort travel somewhere else? O Yes O No **If Yes, where does the pain stop at?** _____

Explain: _____

If numbness/tingling is present, where? Explain: _____

Does any part of your body feel like it is falling asleep? If so, where?_____

For Women Only:

Are you pregnant? O Yes O No	**Chance Pregnant?** O Yes O No
Are you nursing? O Yes O No	**Planning?** O Yes O No

Personal Incident History:

Broken Bones:	O Yes O No	**Explain:** _____
Sprains/Strains:	O Yes O No	**Explain:** _____
Hospitalized:	O Yes O No	**Explain:** _____
Surgery:	O Yes O No	**Explain:** _____
Auto Accident:	O Yes O No	**Explain:** _____
Stroke:	O Yes O No	**Explain:** _____

Personal Health History:

Last Physical Exam: _____ **Primary Physician:** _____ **Physician Phone #:** _____

Health Conditions: _____

Medications: _____

FAMILY HEALTH HISTORY

Patient Name _____ Date _____

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his/her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.

	Father Age ___	**Mother** Age ___	**Spouse** Age ___	**Brother(s)** Age ___ Age ___		**Sister(s)** Age ___ Age ___		**Children** Age ___ Age ___ Age ___		
Condition										
Allergies										
Arm Pain										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Diabetes										
Digestive Issues										
Disc Bulge/Herniation										
Fibromyalgia										
Frequent Colds/Flus										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Hip Pain										
Knee Pain										
Leg Pain										
Low Energy										
Migraines										
Neck Pain										
Numbness/Tingling										
Pinched Nerve										
Sciatica										
Scoliosis										
Shoulder Pain										
Sinus Trouble										
Slipped Disc										
TMJ Pain										
Other:										

Personal Health Checklist:

O Allergies	O AIDS	O Anemia	O Arteriosclerosis	O Arthritis
O Asthma	O Back Pain	O Breast Lump	O Bronchitis	O Bruise Easily
O Cancer	O Chest Pain	O Cold Extremities	O Constipation	O Cramps
O Depression	O Diabetes	O Digestion Problems	O Dizziness	O Eye Pain/Difficulties
O Fatigue	O Excessive Menstruation	O Frequent Urination	O Headache	O Hemorrhoids
O Venereal Disease	O Hot Flashes	O Irregular Heart Beat	O Irregular Menstrual	O Kidney Infection
O Kidney Stones	O Loss of Memory	O Loss of Balance	O Loss of Smell	O Loss of Taste
O Nosebleeds	O Pacemaker	O Polio	O Poor Posture	O Prostate Trouble
O Sciatica	O Shortness of Breath	O High Blood Pressure	O Sinus Infection	O Insomnia
O Spinal Curvatures	O Stroke	O Swelling of Ankles	O Swollen Joints	O Thyroid Condition
O Tuberculosis	O Ulcers	O Varicose Veins	O Other _____	

Goals for Your Care:

People see a Chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor 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.

O **I want the Doctor to select the type of care appropriate for my condition.**

O **Relief Care: Symptomatic relief of pain or discomfort**

O **Corrective Care: Correcting and relieving the cause of the problem as well as the symptom**

O **Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.**

Were you aware that:

Chiropractic is the largest natural healing profession in the world? O **Yes** O **No**

Doctors of Chiropractic work with the nervous system? O **Yes** O **No**

The nervous system controls all bodily functions and systems? O **Yes** O **No**

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____