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CONFIDENTIAL PATIENT INFORMATION

(*Existing Choices Patient)*

Date_____ Phone _____

Name_____ Marital Status S M W D Sex M / F

How many children do you have? _____ Occupation _____

Do you have medical insurance? ___ Yes ___ No

What is your major complaint today? _____
_____

Other Complaints? _____
_____

Are these a result of? ___ Auto Accident ___ Working Accident ___ Neither

How long have you had this condition? _____

What aggravates your condition? _____

Is this condition getting worse? ___ Yes ____ No ___ Constant ___ Comes and goes

Is this condition interfering with your ___ Work ___ Sleep ___ Daily Routine.
Other, Please Describe._____

How often do you see a dentist? ___ Every six months ___ Yearly ___ Toothache or emergency only.

Please list any serious accidents, injuries, and/or falls. (auto, work, home, leisure, other) _____
_____
_____
_____

Do you wear orthotics, heel or sole lifts, in your shoes? ___ Yes ___ No Type: _____

FAMILY HEALTH INFORMATION

(Many health problems are a result of hereditary spinal weaknesses; thus information about your family members will give me a better picture of your total health)

Relationship	Past and Present Health Problems

Please answer the following five questions regarding your occupational situation.

Do you ___ Sit ___ Stand ___Work Bench ___ Desk ___ Counter _____ Other

Does Your job involve ___ Lifting ___ Bending ___ Stooping ___ Twisting ___ Turning
___ Carrying ___ Walking ___ Standing

If you sit, is your chair ___ Executive ___ Steno ___ Bench ___ Stool ___ Folding
Other, please describe _____.

What type of shoes do you wear at work? _____

Do any work activities aggravate your main complaint? _____

What are your sedentary activities? ___ TV ___ Reading ___ Cards ___ Sewing _____
Other, please describe _____

What are your strenuous activities? _____

What is the frequency of these activities? _____

How do you grade your general stress level? ___ None ___ Minimal ___ Moderate ___Great

Have you been to a chiropractor before? ___ Yes ___ No Whom? _____

_____

_____ _____

Patient Signature Date