Skiatook Chiropractic Clinic

First Mi Last

Name_____Date_____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell_____

E-Mail Address_____Social Security#_____

Emergency Name_____Phone #_____Relationship_____

Date Of Birth_____Marital Status: Married_____Single_____Widowed_____

Sex: M F Referred By:_____

INSURANCE:

Insured's Name_____Insured's Social Security_____

Insurance Company:_____Phone:_____

Group #_____Insured's Date of Birth_____

Employer:_____Occupation_____

Employer Phone:_____

Spouse's Name:_____Spouses Employer:_____

Is there any additional Insurance coverage? Yes_____ No_____

If yes, Insurance Name_____ Phone #:_____

Insured's Social Security #:_____ Insured's Date of Birth_____

IF PATIENT IS A MINOR;

Mother's Name: _____ Home Phone #:_____

Employer:_____ Work #:_____ Cell#:_____

Father's Name: _____ Home Phone #:_____

Employer:_____ Work #:_____ Cell#:_____

HISTORY OF CURRENT MAJOR SYMPTOMS

Please describe your major symptom (only your major problem)_____

_____

_____

How did this condition develop? (What caused it? How did it start?)_____

_____

_____

When was the very first time you were aware of this problem?_____

Have you ever had this problem or similar problems before? ☐Yes ☐No If yes, please explain:___

_____

Have you received any treatment for this condition? ☐Yes ☐No If yes, please complete:

Where (Doctor's name)?_____

When (approx. date)?_____

What was the treatment (drugs, manipulation, traction, etc..)_____

What were the results?_____

Has this problem been getting better, worse, or staying the same?_____

Is there anything you do that makes your condition worse?_____

Is there anything that makes your condition better?_____

PAST HISTORY/GENERAL HEALTH HISTORY

Have you ever been in an automobile accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

ANY ACCIDENTS, FALLS, ETC THAT MIGHT HAVE CAUSED YOUR PROBLEM_____

_____

List all Surgeries_____

If Female: Are you pregnant? ☐Yes ☐No How many children did you give birth to?_____

DRUGS YOU NOW TAKE:☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐Insulin

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name:_____

Do you smoke? ☐Yes ☐No Do you consume Alcohol? ☐Yes ☐No

Do you exercise on a regular basis? ☐Yes ☐No If yes, describe the activity, duration, frequency

_____

On the drawing to the right, please indicate where you are experiencing pain by drawing in the letter abbreviation(s) on the diagram that most accurately reflect the type of discomfort you have been experiencing.

N = NUMBNESS T = TINGLING

D = DULL PAIN B = BURNING

P = SHARP PAIN S = STIFFNESS