



Thank you for choosing Washington Park Chiropractic. Please complete this confidential patient form.

Patient Information

Date _____

Name _____ Date of Birth _____
Address _____ SSN _____
City _____ State _____ Zip _____ Gender: Male Female
Preferred Phone _____ Email _____
Emergency Contact _____ Relationship _____ Phone _____

Financial and Insurance Information

Name of party responsible for payment _____ Do you have health insurance? Yes No
_____ Do you have a health savings account? Yes No
Insurance Carrier _____ Are you eligible for Medicare (over age 65) Yes No

Employment Information

Employer _____ Occupation _____
Business Address _____
Hours of computer use daily? _____ Right or Left Handed? _____ Hours worked each week? _____
Hours driving daily? _____ Describe a typical work day _____
Hours on your feet daily? _____

Who may we thank for referring you to our office? _____

Reason for Today's Visit

Please rank your health concerns and rate their severity (on a scale from 1-10, 10 being the worst). **Severity 1-10**
1 _____
2 _____
3 _____
4 _____

Please list conditions you have been diagnosed with or are currently being treated for _____ Treating Practitioner _____

Please list all fractures and dislocations and year _____

List all prior surgeries, hospitalizations and year _____

Please list all allergies _____

Please list all medications and supplements you are currently taking _____

Chiropractic Intake

Current Symptoms

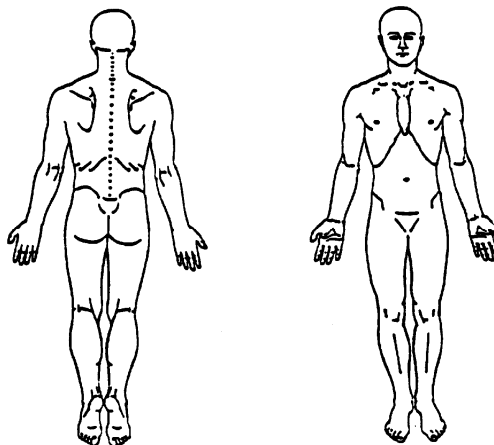
On the diagram to the right please mark **all** areas where you are currently having pain or other abnormal sensation. Please also indicate where your pain travels (if appropriate).

Please Rate Your Pain:

1. Circle the number that best describes your pain at its WORST in the past 24 hours. 1 2 3 4 5 6 7 8 9 10

2. Circle the number that best describes your pain at its LEAST in the past 24 hours. 1 2 3 4 5 6 7 8 9 10

3. Circle the number that best describes your pain on AVERAGE for the past WEEK. 1 2 3 4 5 6 7 8 9 10



Prior Chiropractic Care

Doctor _____ Location _____ Dates of Treatment _____

Why did you initiate care? _____

Why did you discontinue care? _____

Is today's visit due to a car accident? Yes No If yes, date of accident _____

Please list all car accidents by year _____

Lifestyle

Hours of sleep each night 0-2 3-5 6-8 9+ Is your sleep Restful Restless Hard to fall asleep Wake up often

Sports played Golf Snow Ski Water Ski Tennis Running Walking Martial Arts Volleyball
 Swimming Basketball Hockey Snowboard Cycling Fishing Hiking Other _____

Leisure Activities Reading Cooking Music TV Internet Other:

Do you smoke? Yes No How much per day? _____ How much alcohol do you consume weekly? _____

How much coffee/tea/caffeine do you consume daily? _____

Daily water intake: When I'm thirsty 2-4 glasses 5-8 glasses 9-12 glasses Constantly, I'm always thirsty

Women's Health

Date of last Pap Exam _____ Date of last menstrual period _____

Are you Pregnant? Yes No Number of Pregnancies _____ Number of vaginal births _____ Cesareans _____

Review of Systems Please check any symptom or condition that you either have **Now** or in the **Past**:

< Now < Past	< Now < Past	< Now < Past	< Now < Past	< Now < Past
General	Lungs	G-I System	Neurologic	Conditions (cont.)
<input type="checkbox"/> <input type="checkbox"/> Weight loss	<input type="checkbox"/> <input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> <input type="checkbox"/> Heartburn	<input type="checkbox"/> <input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Cataracts
<input type="checkbox"/> <input type="checkbox"/> Weight gain	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Indigestion	<input type="checkbox"/> <input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> <input type="checkbox"/> Glaucoma
Head	<input type="checkbox"/> <input type="checkbox"/> Persistent cough	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Tingling	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Headache	<input type="checkbox"/> <input type="checkbox"/> Coughing blood	<input type="checkbox"/> <input type="checkbox"/> Vomiting/Nausea	<input type="checkbox"/> <input type="checkbox"/> Numbness	<input type="checkbox"/> <input type="checkbox"/> Gallbladder Disease
<input type="checkbox"/> <input type="checkbox"/> Dizziness	Vascular	<input type="checkbox"/> <input type="checkbox"/> Abdominal pain	<input type="checkbox"/> <input type="checkbox"/> Weakness	<input type="checkbox"/> <input type="checkbox"/> Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Head trauma	<input type="checkbox"/> <input type="checkbox"/> Chest pain	<input type="checkbox"/> <input type="checkbox"/> Persistent Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Difficulty walking	<input type="checkbox"/> <input type="checkbox"/> Urinary infection
<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Palpitations	<input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> Poor coordination	<input type="checkbox"/> <input type="checkbox"/> Pneumonia
<input type="checkbox"/> <input type="checkbox"/> Concussion	<input type="checkbox"/> <input type="checkbox"/> Ankle swelling	<input type="checkbox"/> <input type="checkbox"/> Blood in Stool	Muscle/Bone	<input type="checkbox"/> <input type="checkbox"/> Diabetes
Eyes	<input type="checkbox"/> <input type="checkbox"/> Cold feet/hands	<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Joint Pain	<input type="checkbox"/> <input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> <input type="checkbox"/> Changes in vision	<input type="checkbox"/> <input type="checkbox"/> Leg cramps	G-U system	<input type="checkbox"/> <input type="checkbox"/> Stiffness	<input type="checkbox"/> <input type="checkbox"/> Anxiety
<input type="checkbox"/> <input type="checkbox"/> Light sensitivity	<input type="checkbox"/> <input type="checkbox"/> Calf pain	<input type="checkbox"/> <input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> <input type="checkbox"/> Muscle ache	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Spots in vision	<input type="checkbox"/> <input type="checkbox"/> Varicose veins	<input type="checkbox"/> <input type="checkbox"/> Pain urinating	<input type="checkbox"/> <input type="checkbox"/> Bone Pain	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis
Mouth	<input type="checkbox"/> <input type="checkbox"/> Low Blood pressure	<input type="checkbox"/> <input type="checkbox"/> Blood in urine	Conditions	<input type="checkbox"/> <input type="checkbox"/> Parkinson's' Disease
<input type="checkbox"/> <input type="checkbox"/> Jaw pain	<input type="checkbox"/> <input type="checkbox"/> High Blood pressure	<input type="checkbox"/> <input type="checkbox"/> Incontinence	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Gout
<input type="checkbox"/> <input type="checkbox"/> Bleeding Gums	Skin	<input type="checkbox"/> <input type="checkbox"/> Increase urination	<input type="checkbox"/> <input type="checkbox"/> Osteopenia	<input type="checkbox"/> <input type="checkbox"/> High Cholesterol
<input type="checkbox"/> <input type="checkbox"/> Dentures	<input type="checkbox"/> <input type="checkbox"/> Rash	Nose	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> <input type="checkbox"/> Cancer
	<input type="checkbox"/> <input type="checkbox"/> Easy bruising	<input type="checkbox"/> <input type="checkbox"/> Nosebleeds	<input type="checkbox"/> <input type="checkbox"/> Arthritis	
	<input type="checkbox"/> <input type="checkbox"/> Itching/Peeling	<input type="checkbox"/> <input type="checkbox"/> Sinus problems		
	<input type="checkbox"/> <input type="checkbox"/> Changes in moles			

Family History Please list if a parent or sibling has a history of the following

Cancer _____

Heart Disease _____

Hypertension _____

Diabetes _____

Auto-Immune Diseases _____

Epilepsy _____

Arthritis _____

Additional Information / Questions

Are there any specific questions about your condition or chiropractic that you want the doctor to address at today's visit in addition to a thorough history and physical exam?

I certify that 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 the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent 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 Washington Park Chiropractic insurance benefits that are otherwise payable to me. I understand that my chiropractic insurance carrier may cover only a portion of or not cover all of the services rendered.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

X _____
Signature of Patient (or guardian if minor) **Date**