200 E. Joppa Road ▪ Suite 300 ▪ Towson, MD 21286 ▪ 410-296-7700

PERSONAL INFORMATION

Name ____ Date ___________________

Home Address__________________________ City_________________ State ____ Zip __________

Home Phone _______________________________ Work Phone _______________________________

Cell Phone _____________________________ Email Address ________________________________

Contact Pref. H_ W_ C_ Email _ Birth date ___/___/____ Age ____ SS # ______-______-________

Marital Status (circle one) Single Married Divorced Widowed

Number of Children and Ages ____

Employer ___________________________________ Occupation____________________________

SPOUSE'S INFORMATION

Name of Spouse______________________________ Employer _______________________________

Spouse's Birth date ____________________ Spouse's S.S. #______-_______-______________

OTHER INFORMATION

Emergency Contact __________________ Relation ____________________ Phone______________

Whom may we thank for referring you? ____

Have you ever been to a chiropractor? Yes_ No_ Who?_______________________ When? ______

If yes, were the results satisfactory? ____

Purpose of this appointment ____

PRIMARY CARE PHYSCIAN

Physician: ____________________________________ Phone: ________________________
May we update them on your condition? Yes _______ No _______

INSURANCE INFORMATION– If insured, please provide your insurance card to copy.

Relationship to insured Self____ *Spouse____ *Parent____

* If other than "Self" provide Name and Date of Birth of insured:

Name: ___________________________________ D.O.B _________________

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and the policyholder. I authorize this office to release any medical information and to complete any usual and customary reports to assist in collecting information from my insurance company. I understand that I am ultimately responsible for payment in full at this office.

Patient's Signature ____ Date ______________

INJURY INFORMATION

Describe your major complaint ____

When did your problem begin? (specific date if possible) ______________________________

How did your problem begin? ____

____

What increases your pain? ______________________ decreases? ____________________

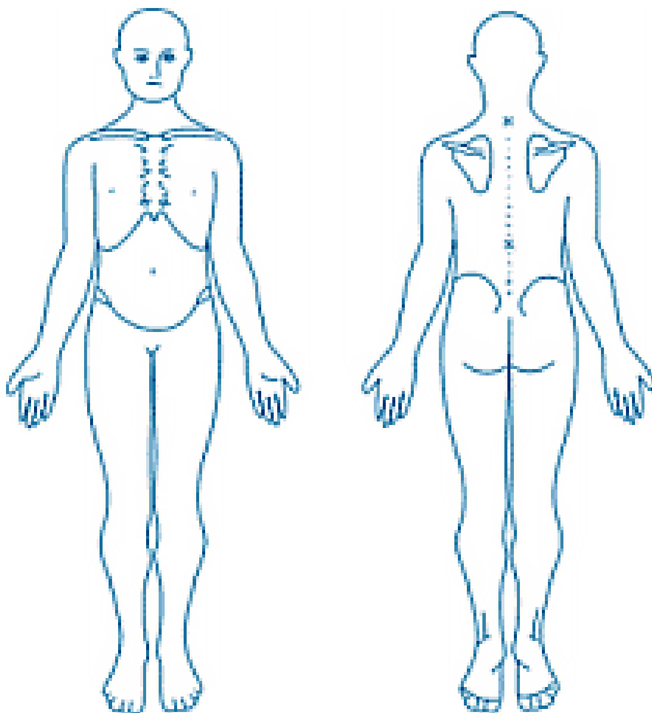
How many days a week do you experience pain/discomfort? ______ days

Are your symptoms ___Decreasing ___Not Changing ___Increasing

Symptoms are worse in the ___Morning ___Afternoon ___Evening ___Same all day

Has your daily activity changed as a result of your condition? If so, please explain.

No__ Yes____



Please check the corresponding pain description and frequency for each area (1,2,3, etc) indicated on the diagram to the left.

Description	Area 1	2	3	4
Sharp pain				
Dull pain				
Ache				
Weak				
Throbbing				
Numb				
Shooting				
Gripping				
Burning				
Tingling				
Frequency				
Constant (76-100%)				
Frequent (51-75%)				
Intermittent (26-50%)				
Occasional (25% or less)				
Other				

Indicate your pain by circling your lowest pain level and highest pain level for each area indicated above.

Area: 1 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

2 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

3 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

4 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

What treatments have you previously tried for this condition?

Physical Therapy ___ Chiropractic ___ Massage ___ Orthopedic ___
Family/Primary Doctor ___ Other ___________________________

if so, please write names and dates ____
____

Have you had Spinal X-Rays, MRI, CT SCAN? __No __Yes:

Date(s) taken: ________ Area taken ________________________________
________ ________________________________

Please list all doctors you are currently seeing and the conditions being treated:
____
____
____

List all prescription, non prescription medications and other supplements you take as well associated condition:
____
____
____
____

List any surgeries, hospitalizations or fractures you have had including month and year:
____
____

List any work, motor vehicle or sports injuries you have had including month and year:
____
____

List any allergies: ____

Do you exercise: ____Yes ____No Hours per week?____

What activities:____

Are you dieting? ____Yes ____No Since?___

Do you smoke? ____Yes ____No Packs per day?____ How many years? ____

Do you drink alcoholic beverages? ____Yes ____No Drinks per day _____

For Women: Are you pregnant/nursing? ____Yes ____No How many weeks: _____

Last menstrual cycle:__________________________

Please circle all that apply:

Musculoskeletal Conditions
Arthritis
Back problems
Cramping
Elbow/wrist pain
Foot/ankle pain
Fracture
Gout
Hip disorders
Implants or plates
Joint or muscle pains/stiffness
Knee injuries
Neck pain
Osteoporosis
Pins or screws
Scoliosis
Shoulder problems
Swelling, redness, or deformity of joint(s)
TMJ issues

Neurological Conditions
Anxiety/Depression
Dizziness
Epilepsy or seizures
Headache or Migraine
Loss of smell or taste
Memory issues
Numbness
Pins and needles
Stroke
Weak muscles

Endocrine Conditions
Diabetes
Excessive thirst
Heat or cold intolerance
Increase or excessive urination
Pancreatic conditions
Steroid treatments
Testosterone deficiency
Thyroid problems

Respiratory
Sleep Apnea
Asthma
Emphysema
Persistent cough
Pneumonia
Shortness of breath

Genitourinary
Blood in the urine
Incontinence
Kidney stones
Painful or frequent urination
Urinary infection

Ears, Eyes, Nose and Throat Conditions
Blurred or double vision
Cataracts
Dental problems or implants
Difficulty swallowing
Hearing problems
Ear infections
Vision problems
Eye surgery
Glaucoma
Sinus congestion
Photophobia
Hearing loss
Ringing in ears
Swollen lymph nodes
TMJ problems

Cardiovascular Conditions
Blood clots
Chest pain or tightness
Congenital heart defects
Coronary artery disease
Dyspnea
Heart attack
Heart murmur
High blood pressure
High cholesterol
Leg pain upon walking
Low blood pressure
Lower extremity edema
Palpitations

Dermatological or Hematopoietic Conditions
Change in hair or nail
Easy bruising
Eczema
Excessive acne
Hypo/hyper pigmentation
Psoriasis
Skin cancer
AIDS/HIV

Gastrointestinal Conditions
Abdominal pain
Black or bloody stool
Change in bowel habits
Colitis
Colon cancer or polyps
Constipation
Crohn's disease
Gastric reflux
Heartburn
Hemorrhoids
Irritable bowel syndrome
Liver disease
Nausea or vomiting
Pancreatitis

Family Health History
Cancer
Congenital anomaly
Hereditary disorder
Alzheimer's
Anemia
Anxiety/Depression
Arthritis
Asthma
Bleeding disorders
Chemical dependency
Diabetes
Heart disease
High blood pressure
High cholesterol
Kidney disease
Liver disease
Multiple sclerosis
Osteoarthritis
Osteoporosis
Pacemaker
Parkinson's disease
Rheumatoid arthritis
Stroke
Thyroid problems
Tumor

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amounts owed this office.

Patient Signature: ____ Date: __________________