MATHEWS
Family Chiropractic

Patient Name

Today's Date: _____

Patient Last Name: _____

First Name: _____

Middle Initial: _____

Patient Information

SS/HIC/Pat.ID# _____

Address: _____

City: _____

State: _____

Zip Code: _____ Sex ◯ M ◯ F

E-Mail _____

Birthdate _____

◯ Married ◯ Widowed ◯ Single ◯ Minor

◯ Separated ◯ Divorced ◯ Partnered

Occupation _____

Patient Employer/School _____

Whom may we thank for referring you?

Insurance

Who is responsible for this account: _____

Relationship to Patient: _____

Subscriber's Birthdate: _____

Phone Number: _____

If billing address is different than patient address please list below:

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Numbers

Home Phone _____

Cell Phone _____

In Case of Emergency, Contact

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

Accident Information

Is this condition due to an accident: ◯ Yes ◯ No

Date: _____

Type of Accident: ◯ Auto ◯ Work ◯ Home ◯ Other

To whom have you made a report of your accident?

◯ Auto Insurance ◯ Employer ◯ Worker Comp. ◯ Other

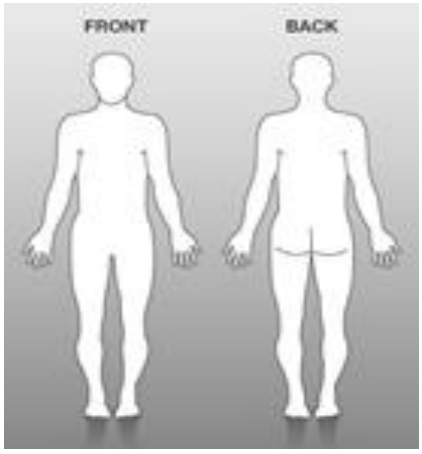
Patient Condition

Reason for visit: _____

What date did your symptoms appear? _____

Is this condition getting progressively worse? ◯ Yes ◯ No ◯ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling



Rate the severity of pain on a scale from 1(least pain) to 10 (severe pain)_____

Type of Pain: ◯ Sharp ◯Dull ◯Throbbing ◯Numbness ◯Aching ◯Shooting

◯ Burning ◯Tingling ◯Cramps ◯Stiffness ◯Swelling ◯Other

How often do you have this pain? _____

Is it constant or does it come & go? _____

Does it interfere with your ◯Work ◯Sleep ◯Daily Routine ◯Recreation

Activities or movements that are painful to perform ◯Sitting ◯Standing ◯Walking ◯Bending ◯Lying Down

Health History

What treatment have you already received for your condition? ◯ Medications ◯ Surgery ◯ Physical Therapy ◯ Chiropractic Services ◯ None ◯ Other _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on the "◯" beside Yes or No to indiciate if you have had any of the following:

AIDS/HIV	◯Yes	◯No	Fractures	◯Yes	◯No	Rheumatoid Arthritis	◯Yes	◯No
Alcoholism	◯Yes	◯No	Glaucoma	◯Yes	◯No	Rheumatic Fever	◯Yes	◯No
Allergy Shots	◯Yes	◯No	Goiter	◯Yes	◯No	Scarlet Fever	◯Yes	◯No
Anemia	◯Yes	◯No	Gonorrhea	◯Yes	◯No	Stroke	◯Yes	◯No
Anorexia	◯Yes	◯No	Gout	◯Yes	◯No	Suicide Attempt	◯Yes	◯No
Appendicitis	◯Yes	◯No	Heart Disease	◯Yes	◯No	Thyroid Problems	◯Yes	◯No
Asthma	◯Yes	◯No	Hepatitis	◯Yes	◯No	Tonsillitis	◯Yes	◯No
Bleeding Disorder	◯Yes	◯No	Hernia	◯Yes	◯No	Tuberculosis	◯Yes	◯No
Breast Lump	◯Yes	◯No	Herniated Disk	◯Yes	◯No	Tumors, Growths	◯Yes	◯No
Bronchitis	◯Yes	◯No	Herpes	◯Yes	◯No	Typhoid Fever	◯Yes	◯No
Bulimia	◯Yes	◯No	High Cholesteral	◯Yes	◯No	Ulcers	◯Yes	◯No
Cancer	◯Yes	◯No	Kidney Disease	◯Yes	◯No	Vaginal Infections	◯Yes	◯No
Cataracts	◯Yes	◯No	Liver Disease	◯Yes	◯No	Venereal Disease	◯Yes	◯No
Chemical			Measles	◯Yes	◯No	Whooping Cough	◯Yes	◯No
Dependency	◯Yes	◯No	Migraines	◯Yes	◯No		◯Yes	◯No
Chicken Pox	◯Yes	◯No	Miscarriage	◯Yes	◯No	Other	_____	
Diabetes	◯Yes	◯No	Mononucleosis	◯Yes	◯No	_____		
Emphysema	◯Yes	◯No	Multiple Sclerosis	◯Yes	◯No	_____		
Epilepsy	◯Yes	◯No	Mumps	◯Yes	◯No			

Exercise	Work Activity	Habits	
◯ None	◯ Sitting	◯ Smoking	Packs/Day _____
◯ Moderate	◯ Standing	◯ Alcohol	Drinks/Week _____
◯ Daily	◯ Light Labor	◯ Coffee/Caffeine Drinks	Cups/Day _____
◯ Heavy	◯ Heavy Labor	◯ High Stress Level	Reason

Are you pregnant? ◯ Yes ◯ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy:		
Phone:		