East Aurora CHIROPRACTIC

Name:____ **Date:**__________________

Address:_________________________________City:_________________State: _____ Zip:________________

SS #:____________________ Sex: ❍M ❍F Home phone:_______________ Work phone____________________

Date of Birth:_________ Age:____Height:________ Weight:________ Referred by:______________________________

Work Status: ❍ full time ❍ part time ❍ other_____________ Marital status: ❍M ❍S ❍Other

Emergency Contac Name & Phone:____

Employer Information:

Employer:_______________________Occupation:__________________________Employer phone #:_______________

Address:____________________________________ City:________________________ Zip:_________________

Are you currently receiving disability income or involved in injury/disability litigation?______________________________

Insurance Information

Plan Name:_________________________________ Group/Plan #______________________

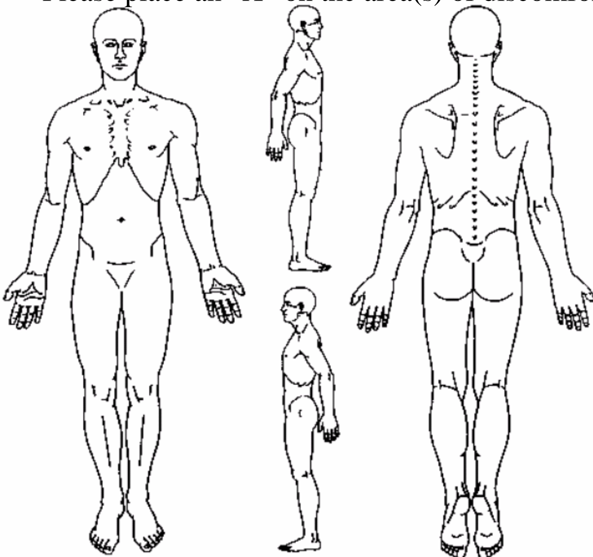
Insured name *(if different than yours)*:________________________________ Insured Date of Birth:_________________

Insured SS# *(if different than yours)*:____________________________ Insured Employer__________________________

- Present Symptoms/complaint/reason for treatment: ____
____
____

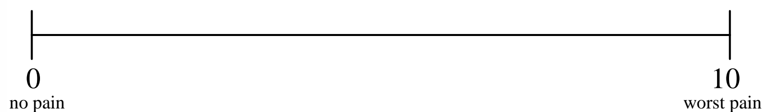
Have you ever been to a chiropractor before? ❍ Yes ❍ No *Name(s)*__________________________________

Please place an "X" on the area(s) of discomfort/pain



Please place an "X" on the line below to grade the discomfort:

(scale of 1-10)



0 no pain — 10 worst pain

- Did these symptoms developed from: ❍ Auto accident ❍Work-related ❍ other____________________________
- If work or auto, did you report it to your insurance company or employer? ❍ Yes ❍No
- When did symptoms begin? *(specific date?)*_________________
- Have you experienced these symptoms before? ❍ Yes ❍No
If so, When?____________________________
- What aggravates this condition?
❍ Lying down ❍ Walking ❍ Standing ❍ Sitting ❍ Inactivity ❍ Nothing
❍ Movement/exercise ❍Other:____
- What lessens this condition?
❍ Lying down ❍ Walking ❍ Standing ❍ Sitting ❍ Inactivity ❍ Nothing
❍ Movement/exercise ❍ Other:____

(continued on other side)

- Have you seen a doctor for this condition? ❍ Yes ❍ No Doctor's Name:______________________________
  Date consulted:___________________ Diagnosis:____
- Does this condition interfere with sleep? ❍ Yes ❍ No
- Does heat affect the pain? ❍ Yes ❍ No If so, how?________________________________
- Does cold affect the pain? ❍ Yes ❍ No If so, how?________________________________
- Is it painful to cough or sneeze? ❍ Yes ❍ No If so, where?_______________________________
- Do you wear a heel lift? ❍ Yes ❍ No If so, which side? ❍ Right ❍ Left
- If female, are you pregnant? ❍ Yes ❍ No ❍ not sure If yes, when is your due date?_______________

List all medications you are now taking, including over the counter:_______________________________________
____
____
____

Are you allergic to any medications? ❍ Yes ❍ No ❍ not sure If so, please list:___________________________
____

PLEASE CHECK ACTIVITIES BELOW DURING WHICH YOU EXPERIENCE DIFFICULTY OR PAIN:

❍ lying of back	❍ getting in/out of car	❍ sleeping	❍ stooping	❍ climbing
❍ lying on side	❍ coughing	❍ pushing	❍ pulling	❍ sitting
❍ bending forward	❍ sneezing	❍ getting dressed	❍ reaching	❍ gripping
❍ bending backward	❍ kneeling	❍ walking	❍ sexual activity	❍ breathing
❍ turning over in bed	❍ standing more than 1 hour		❍ other______________________	

Please check any additional complaints/conditions you have or have had in the past:

❍ Headaches	❍ Neck stiffness	❍ Loss of consciousness	❍ Cold feet	❍ Arthritis
❍ Irritability	❍ Restricted neck movement	❍ Loss of concentration	❍ Jaw pain	❍ HIV
❍ Sensitivity to light	❍ Upper back pain/stiffness	❍ Anxiety	❍ Cancer	❍ Diabetes
❍ Vision problems	❍ Middle back pain/stiffness	❍ Depression	❍ Hypertension	❍ Hepatitis
❍ Memory loss	❍ Lower back pain/stiffness	❍ Insomnia	❍ Convulsions	❍ Nausea
❍ Dizziness	❍ Right/left shoulder pain	❍ Fatigue	❍ Flushed face	❍ Vomiting
❍ Ringing in the ears	❍ Right/left arm pain	❍ Excess perspiration	❍ Diarrhea	❍ Fainting
❍ Loss of balance	❍ Right/left leg pain	❍ Digestive trouble	❍ Constipation	❍ Anemia
❍ Loss of smell	❍ pins and needles arms/legs	❍ cold hands	❍ Chest pain	
❍ Loss of taste	❍ Sinus trouble	❍ Shortness of breath	❍ Nervousness	
❍ Pain behind eyes	❍ Palpitation	**Please specify location:**		
❍ Heart disease	❍ neck pain	❍ Numbness ____________________		
❍ Allergies: (please list)	❍ Other: (please list)	❍ Swelling ____________________		
____________________	____________________	❍ Cuts ____________________		
____________________	____________________	❍ Bleeding ____________________		
____________________	____________________	❍ Broken bones____________________		
____________________	____________________	❍ Bruising ____________________		

Have you ever had any surgeries or hospitalizations (including breast augmentation)? ❍ Yes ❍ No ❍ not sure

Type of Hospitalization/surgery	*Date:*	*Type of Hospitalization/surgery*	*Date:*
________________________	__________	____________________________	__________
________________________	__________	____________________________	__________

Have you been x-rayed in the past 12 months? ❍ Yes ❍ No When?________________________________

***I certify the above information to be true and correct to the best of my knowledge. I do hereby authorize this office to do whatever is necessary, in accordance with the state statutes, for care and management of this complaint. I also acknowledge that East Aurora Chiropractic will keep this information strictly confidential in accordance with HIPPA regulations, and will not release information without my consent.*

*Print Name:*____________________________________ *Date:*______________________

*SIGN NAME*____________________________________ *Date:*______________________