Beverly Family chiropractic

Date _____

PATIENT INFORMATION

First Name _____ Occupation _____

Last Name_____ Hobbies _____

Address _____ Spouse/Partner's Name _____

City _____ State _____ Children's Ages _____

Cell Phone _____ **IN CASE OF EMERGENCY, CONTACT:**

Home Phone _____ Name _____

Email _____ Relationship _____

Date of birth _____ Height _____ Weight _____ Number _____

Who may we thank for referring you? _____

Have you seen a chiropractor in the past? ☐Yes ☐No Last visit: _____

If so, **how** was your experience? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom or health challenge, what is it? _____

When did it start? _____

How did it start? _____

What have you tried that has helped? _____

What you tried that has NOT helped? _____

What makes it worse? _____

What does it feel like? (check where appropriate) ☐Sharp ☐Dull ☐Burning ☐Achy ☐Numb ☐Tingling ☐Other _____

Does it move around? ☐Yes ☐No Describe: _____

How bad does it get? (on a 0-10 scale, with 10 being the worst)

Mild < 0☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10 > Severe

Do other health challenges bring you into the office? ☐Yes ☐No

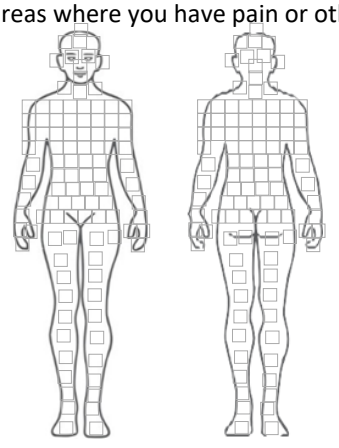
Describe: _____

Have you ever injured your spine/nervous system? ☐Yes ☐No

Describe: _____

If you have no specific health challenges and are here to become healthier and more well, check here: ☐

Please select areas where you have pain or other symptoms.



IMPACT OF YOUR SYMPTOMS

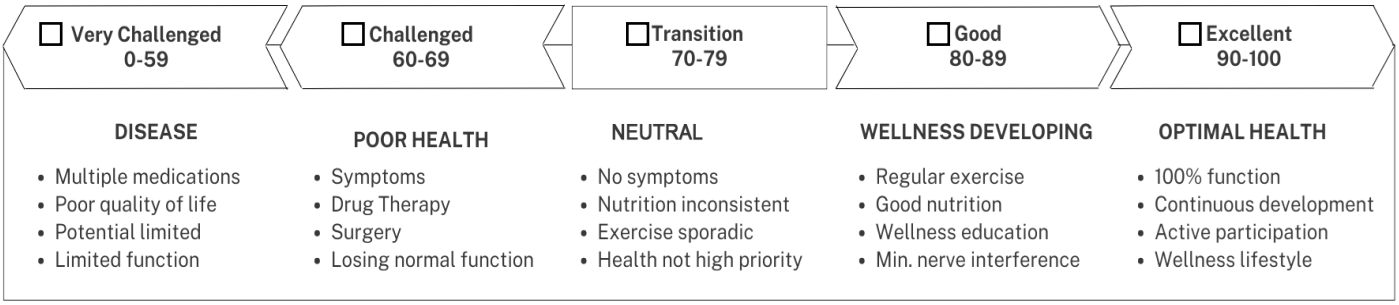
How is this symptom/health challenge interfering with your life? **None < 0☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10 > Severe**

Is this condition interfering with your: ☐Sleep ☐Work ☐Exercise ☐Hobbies ☐Energy ☐Attitude ☐Self-care ☐Relationships

How committed are you to correcting this issue? **Not committed < 0☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10 > Very committed**

PATIENT WELLNESS ASSESSMENT

On the diagram below, put an **X** where you believe your health is



GENERAL HEALTH PROFILE

Please check all symptoms and conditions you have or have had, even if they do not seem related to your primary complaint.

☐Neck Pain	☐Loss of concentration	☐Midback pain	☐Loss of taste	☐Cancer
☐Headaches	☐Earaches	☐Chest pain	☐Weight gain	☐Skin conditions
☐Pins/Needles in arms	☐Buzzing in ears	☐Heart disease	☐Weight loss	☐Fatigue
☐Shoulder pain	☐Low back pain	☐Heartburn	☐Loss of balance	☐Cold sweats
☐Numbness in fingers	☐Pins/Needles in legs	☐Diarrhea / Constipation	☐Sleeping problems	☐Hot flashes
☐Cold hands	☐Numbness in toes	☐Urinary problems	☐Sinus trouble	☐Irritability
☐Dizziness / Fainting	☐Cold feet	☐Allergies / Asthma	☐Anxiety	☐Mood swings
☐Stroke	☐Ankle/foot problems	☐Difficulty breathing	☐Depression	☐Other _____
☐Osteoporosis	☐Knee pain	☐Loss of smell	☐Hormone problems	_____

MEDICATIONS, ALLERGIES, & SUPPLEMENTS

Medications (List)	Allergies (List)	Supplements (List)
_____	_____	_____
_____	_____	_____
_____	_____	_____

TRAUMA, SURGERIES, STRESS

Trauma, Injuries, Concussions (List)	Surgeries (List)	Chemical or Emotional Stress (List)
_____	_____	_____
_____	_____	_____
_____	_____	_____

What do you think is the biggest challenge holding you back from the achieving the level of health you truly want? _____

_____