Discover Chiropractic

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Patient Name ______________________________ Today's Date ______________

Birthdate ______________ Age ______ Sex: M / F Status: M / S / D / W # of Children __________

Address ______________________________ City ______________ Zip __________

Cell Phone # ______________ Home Phone # ______________ Email ______________

Occupation: ______________ Employer: ______________ Work Phone # __________

Emergency Contact Name & Phone # ______________________________

Primary Care Physician ______________________ PCP Phone # ______________

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other ______________

Is This? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began ______________ How Problem Began ______________________________

Did the problem begin: Gradually? Suddenly? ______________________________

On a 1-10 pain scale, where "0" is no pain and "10" is the worst possible pain, how would you rate your problem?

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Now ______________ At its worse? ______________ On average? ______________ Prior to DOI? ______________

How often are your symptoms present?

Occasional ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% Constant

In the past week, how much has your pain interfered with your daily activities (i.e. work, social, household)

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

In general how you say your overall health is right now?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ NO ☐ Yes

Date(s) taken: ______________ What areas were taken? ______________________________

Please check all of the following that apply to you: (Use the back side of this sheet if necessary)

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date) __________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain) __________
☐ Piercings Where? __________
☐ Tattoos Where? __________
☐ Cancer/Tumor (Explain) __________
☐ Other Significant Illnesses/Concerns __________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks __________
☐ Abnormal Weight Gain Loss
☐ Marked Morning Pain/Stiffness
☐ Difficulty Sleeping
☐ Visual Disturbances
☐ Surgeries __________
☐ Scars __________
☐ Hemorrhoids
☐ Tobacco Use - Type __________
☐ Depression / Anxiety
☐ Spinal Abnormalities
☐ TMJ Dysfunction
☐ Medications __________

Family History:

☐ Cancer / Type? __________
☐ Diabetes
☐ High Blood Pressure
☐ Heart Problems/ Stroke
☐ Rheumatoid Arthritis

Mark painful areas:

Consent For Treatment: I, the undersigned, have voluntarily applied for and agree to participate in treatment with Dr. Ingrid Fullerton. The ultimate responsibility of the fees is that of the undersigned. My signature indicates my understanding and acknowledgement of the foregoing information.

Patient's Signature: ______________________________ Date: ______________