Mink Chiropractic Center

TODAY'S DATE:
_____

For Office Use
Dr _____ Case _____
Pt#_____ Last Vt_____

Name: _____YOUR Preferred Name_____
(First..Middle..Last)
Address: _____ City, ST, Zip _____

Home Phone: _____ Work Phone: _____

Appointment Reminders are automated and delivered on the day before and the day of your appointment

Cell Phone: _____ Reminders : Yes ☐ NO ☐

E-mail _____

Date of Birth: _____ Age ____ Male ☐ Female ☐ Marital Status -- M S W D

Occupation:_____ Employer;_____

Spouse's Name: _____ Spouse's Occupation:_____

The Patient's Parent or Guardian (Patient is under 18 years old) _____

Main reason for today's visit: _____

Family Physician: _____ Name of Facility: _____

Person to contact in case of emergency (Name, Phone & Relationship)_____

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury AND another party will be responsible? Yes _____ No_____

Are you pregnant? Yes ☐ No ☐ N/A ☐

What surgeries have you had? _____ When? _____

Serious Illness/Injuries: _____ When? _____

Are you taking medications now? _____If YES what TYPE med's are you taking? (TYPE): Pain Killers __ Insulin ___
Cholesterol Meds ____ Anxiety_____ Sleeping med's ____ Blood Pressure___Muscle Relaxer ____Birth Control_____
Other types _____
Smoking history: Never smoker _____ Former Smoker _____ Current Smoker_____(daily or occasional)

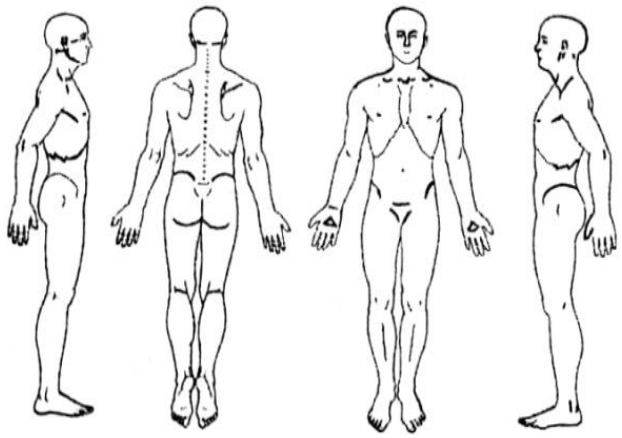
Are you on a vitamin or Nutrition Program? YES _____ NO _____ Describe program: _____

Would you be interested in learning what vitamins in our shop could benefit you? YES_____ NO_____

If so, please list the five main physical complaints you have in order for our doctors to better understand what vitamins would benefit you the most.
1._____2._____3._____4._____5._____

What is your goal in our office? _____

Name _____



Please circle the areas on the figures to the right where you experience pain

1. When did your symptoms begin? _____
2. Circle the things that make your problems worse:

   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting
3. Is there anything you can do to relieve the problems? No ___ Yes ___ Describe: _____
4. Have you been treated for this before? No ___ Yes ___ How long ago? _____
5. What treatment did you receive? _____
6. Results of previous treatment? Good ___ Poor ___ Comments _____
7. Approximate date of last Chiropractic treatment? _____

Below is a list of problems that may be important for the Doctor to be aware of. Please check any that you may have had in the past 6 months.

- ❑ Upper Back Pain
- ❑ Mid Back Pain
- ❑ Low Back Pain
- ❑ Hip Pain
- ❑ Neck Pain
- ❑ Arm/Leg Pain
- ❑ Foot/Hand Pain
- ❑ Knee/Shoulder/Elbow/Wrist Pain
- ❑ Jaw Pain
- ❑ Nausea/Vomiting
- ❑ Diarrhea/Constipation
- ❑ Abdominal Pain/Urinary Trouble
- ❑ Chest Pain/Short Breath
- ❑ Numbness/Tingling
- ❑ Dizziness/Fainting Vertigo
- ❑ Sleep Problems/Fatigue
- ❑ Headaches/Migraines
- ❑ Stress/Anxiety
- ❑ Allergies
- ❑ Blood Pressure Problems
- ❑ Ankle Swelling
- ❑ Earaches
- ❑ Menstrual Problems
- ❑ Heart Problems
- ❑ Lung Problems
- ❑ Stroke

(This area for Dr's Notes)

I certify that the above information is accurate to the best of my knowledge.

Patient's Signature (over 18)_____ Date_____

Guardian's Signature (For under 18) _____ Date: _____