

Andan Chiropractic

Case Number _____

Date _____

Tell Us About You

Name _____ Email _____

Nickname _____ Birth date _____ Age _____ Sex: Male Female

Address _____

SS # _____ - _____ - _____ Whom may we thank for referring you? _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Ext _____

Mobile Phone _____ - _____ - _____ Preferred contact: Home Work Cell

Single Divorced Separated Widowed Married to _____

of children _____ Names/Ages of children _____

Employed Full-time Employed Part-time Self-employed Unemployed Retired Student

Occupation _____ Employer/School _____

Emergency Contact: _____ Relationship _____ Phone: _____ - _____ - _____

What is the primary reason for your visit? _____

Is this due to a: Automobile accident Work-related injury Personal injury case Other

When did your pain/symptoms begin (date if possible)? _____

Have you had recent treatment for this condition? No Yes—please describe, list dates and doctors:

Have you had the same or similar problems in the past? No Yes—When: _____

Do you have any additional complaints/concerns/health problems? No Yes—please describe:

Prior Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury): _____

Prior illnesses (other than colds and flu): _____

Surgeries and hospitalizations: _____

CAT scans, MRI, X-rays in past five years (type and date) _____

Are you currently taking ANY over-the-counter medication: No Yes—list name and for what condition.

Are you currently taking ANY prescription medication: No Yes—list name and for what condition.

Remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control pills, blood pressure pills, etc.

<u>DRUG</u>	<u>CONDITION</u>	<u>DRUG</u>	<u>CONDITION</u>	<u>DRUG</u>	<u>CONDITION</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Your Health Habits and Lifestyle

Which is your dominant hand: Left Right Ambidextrous

Which of the following best describes your stress level: None Minimal Moderate Extreme

Do you smoke? No Yes—How much: _____

Do you exercise? No Yes—How often: _____

How many caffeinated drinks do you consume: _____ per day

How many alcoholic drinks do you consume: _____ per week

Do you have weight issues? No Yes _____

Are you currently taking any vitamins or nutritional supplements: No Yes—please indicate which one(s):

Do you have any heavy metal toxicity? No Yes—_____ Unknown

Do you have any "silver" or amalgam dental fillings in your mouth? No Yes Unknown

Do you have any body piercings (aside from ear piercings)? No Yes

What type of water is in your home? City Well—Date last tested: _____

Do you sleep on your stomach? No Yes Do you carry a wallet in your back pocket? No Yes

How often do you consume processed or prepared foods? Occasionally Frequently Usually

Are the cosmetics and/or personal grooming products you use: Mainstream All natural or organic

Are the cleaning products and laundry detergent in your home: Mainstream All natural or organic

Have you ever been a victim of sexual or physical abuse? No Yes _____

If so, would you like a referral to the proper authorities? No Yes

WOMEN ONLY: To your knowledge are you pregnant? No Yes—Due date: _____

Other Health Care Providers

Have you ever been to a doctor of chiropractic before? No Yes—How long ago? _____

Name of previous chiropractor: _____

City: _____ State: _____

Do you see a medical doctor or osteopath? No Yes—Date of last visit: _____

Name of medical doctor: _____

City: _____ State: _____

Communication is Key to a Positive Relationship

Is there anything else you would like us to know? No Yes—_____

Signature: _____

Date: _____