ADVANCED PAIN & SPINE CENTER
Non-Surgical Pain Relief

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Woodstock, GA 30188
www.chiropractor-woodstock.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:			**Date:**
Address: Street	City	State	Zip
Home phone:	**Work phone:**		
Cell phone:	**Email address:**		
Best time/place to contact you:			
Date of birth:	**Age:**		
No. of children:	**Pregnant?** Yes ☐ No ☐		
Height:	**Weight:**		
Driver's license number:			
Marital status: M S W D	**Spouse/guardian name:**		
Occupation:			
Employer's name & address:			
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Do you have insurance that covers Chiropractic care? Yes ☐ No ☐	**Do you have Medicare coverage?** Yes ☐ No ☐		
Name of Insurance Company:			
Insurance Policy number:	**Insurance Company phone number:**		
Insurance Company address:			

Who may we thank for referring you? _____

Emergency Contact and Phone:_____

Addressing What Brought You Into This Office: _

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Reasons for your visit

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

Does your pain radiate, if so where?

_____

Please describe your pain. (Is your pain dull, sharp etc..)?

_____

What have you done for this condition and was it of benefit? _____

What aggravates your condition? _____

Other doctors you have seen for this condition:

Type	Doctor/Office name	Date of visit	Diagnosis	Treatment	Help? Y/N
Chiropractor					**Y N**
Medical Doctor					**Y N**
Orthopedist					**Y N**
Other (please describe)					**Y N**

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal.

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Are you interested in losing weight? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs/supplements you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

□ Alcoholism	□ Allergy	□ Anemia	□ Arteriosclerosis	□ Arthritis	□ Asthma
□ Back Pain	□ Cancer	□ Cold Sores	□ Constipation	□ Convulsions	□ Depression
□ Diabetes	□ Diarrhea	□ Eczema	□ Emphysema	□ Epilepsy	□ Gall Bladder
□ Gout	□ Headaches	□ Heart Attack	□ Heart Disease	□ High Blood Pressure	□ HIV (Aids)
□ Irregular Periods	□ Low Blood Sugar	□ Malaria	□ Measles	□ Menstrual Cramps	□ Migraines
□ Miscarriage	□Multiple Sclerosis	□Mumps	□ Neck Pain	□ Nervousness	□ Neuritis
□ Pleurisy	□ Plantar Fasciitis	□ Polio	□ Rheumatic Fever	□ Ringing in ears	□Sinus Problems
□ Stroke	□ Thyroid Problems	□Tuberculosis	□ Ulcers	□ Venereal Disease	□

Other (please explain) _____

Stressors

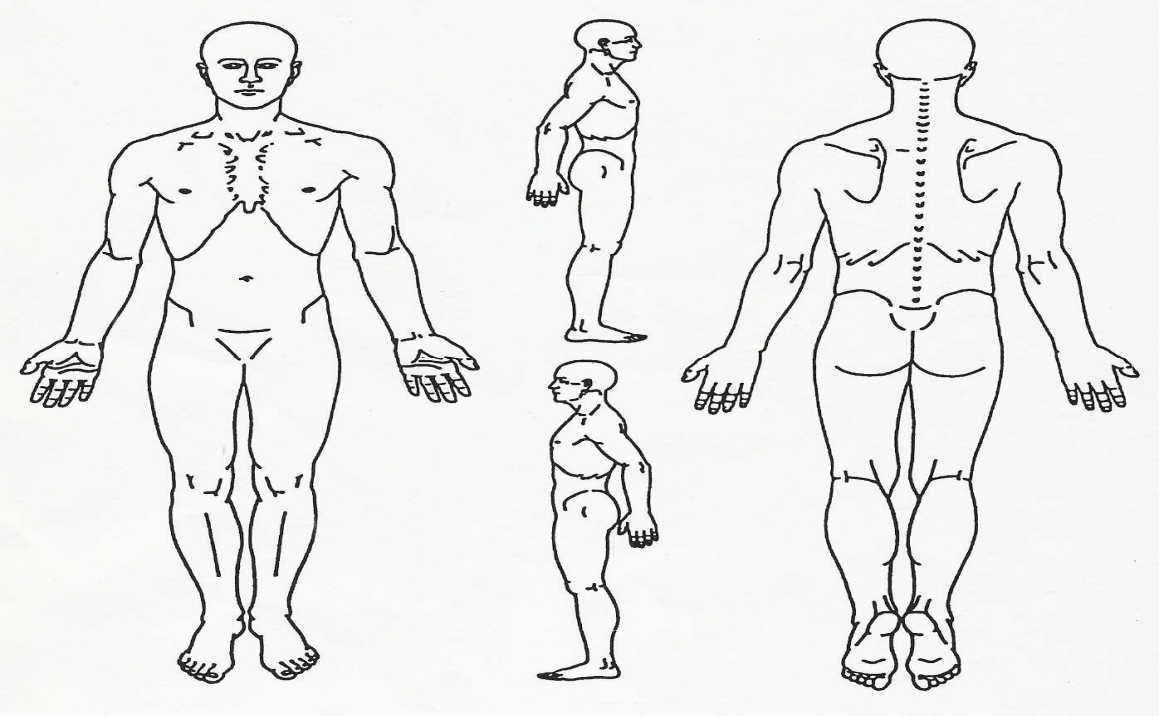
Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category: (physical, chemical and psychological) List as many as apply to you.

1. Example (falls, smoking, home stress, etc.)
   a. _____
   b. _____
   c. _____

PAIN DRAWING

Please mark the figures below with the **letters that best describe the sensation or pain you are feeling and numbers rating your pain from 1-10** (10 being excruciating pain) for each complaint. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



I consent to a professional and complete chiropractic examination and understand that in order to better serve me, the doctor may refer me for other tests or treatment before beginning care in this office. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____