5930 Hamilton Blvd.
Suite 8
Allentown, PA 18106
(610) 841-2204

Patient History

Date:_____________ Whom may we thank for referring you? _______________________

Patient Information

Name:_________________________________ Sex:______ Age:______ Birth date:_________
Address:____
Martial Status: S M D W SS#:_____-_____-_____ Height:__________ Weight:___________
Do you have children? Y N If so, how many?:_________________
Are you pregnant? Y N Due Date:___________
Primary Care Physician Name:_______________ City_____________ Date last seen:_______
May we contact your PCP regarding your care at this office? Yes / No
Previous Chiropractor: _____________ City ____________ Date last adjusted?________
Occupation:______________________ How long?_____________

Contact Information

Phone # (H):________________ Phone # (cell):_________________
Phone # (W):________________ Email:___________________________
What is the best time and way to reach you?_________________________
Would you like to receive our monthly informative health e-newsletter? (you may opt out at anytime) Y N
May we contact you with office happenings via email? (approx. 4-6 a yr.) Y N
Emergency contact:_______________________ Relationship:________________
Phone Number:___________________________

Patient Condition

Please list in order of importance the reason(s) you are seeking care at Complete Chiropractic:
1.________________________________ 2.__________________________________
3.________________________________ 4.__________________________________

Describe your primary reason for seeking care_____________________________________
____
When did your symptoms start?______________ How did it occur? _______________________
Is the condition getting worse? Y N Unknown Worse at certain time of day?______________
Is it constant or does it come and go? Constant comes and goes don't know
Does your condition interfere with work sleep daily routine recreation
Activities that are painful: lifting bending sitting walking standing other:_______________
Have you seen any other providers for your complaint? Y N
If yes, please list names and specialties:_______________________________________
What treatments, if any, have you received for your complaint?_____________________
____
Have you had any x-rays? Y N If yes, date:__________ For what?________________
Have you had an MRI? Y N If yes, date:__________ For what?_________________
Medications:____
____
Supplements and brands:____
Is your current condition the result of a car or work accident? Y N
If yes, which one?_________
To whom have you reported your accident? Auto insurance worker's comp. employer
other:____________________ Attorney's name, if applicable:_________________

Health History

Have you had or currently have any of the following? **Please indicate *P* if you are presently experiencing the problem or *E* if you have ever had the problem**.

Neck Pain	___	Weakness in Legs	___	Osteoporosis	___
Swelling of Joints	___	High Blood Pressure	___	Miscarriage	___
Neck Stiffness	___	Pins/Needles in Arms	___	Knee Pain	___
Chest Pain	___	High Cholesterol	___	Eye/Vision Problems	___
Headaches	___	Pins/Needles in Legs	___	Abdominal Pains	___
Difficulty Breathing	___	Stroke	___	Shoulder Pain	___
Dizziness	___	Pinched Nerve	___	Frequent Urination	___
Asthma	___	Liver Disease	___	Mid back Pain	___
Loss of Balance	___	Low Back Pain	___	Arm Pain	___
Depression/Anxiety	___	Kidney Disease	___	Heart Problems	___
Fever	___	Sciatica	___	Unexplained Weight Loss	___
Diabetes	___	Hip Pain	___	Other:____________________	
Change in bowel or bladder function	___	Herniated Disc	___	_________________________	
		Arthritis	___		

Current of Former Major Illnesses or Injuries

	Description	Date
Major Illnesses	______________________________	__________
Surgeries/Broken Bones	______________________________	__________
Falls/Car Accidents	______________________________	__________
Hospitalizations	______________________________	__________
Allergies	______________________________	__________
Other	______________________________	__________

Social History

Do you exercise? Y N If so, how often and what type?________________________

Do you have a well balanced diet? Y N Please describe:________________________

Have you ever smoked? Y N Currently Packs/day:_____________ Years:__________________

Do you consume coffee/caffeine? Y N Cups/day:______________________

Do you drink alcohol? Y N Drinks/Week:___________________

Do you have a high stress level? Y N Reason:________________________

Do you use recreational drugs? Y N

Work Activities: Sitting Standing Light Labor Heavy Labor

Please describe:____

Family History

Has anyone in your immediate family had any of the following?

Diabetes	Y N	Kidney Disease	Y N	Arthritis	Y N
Cancer	Y N	Back Problems	Y N	Osteoporosis	Y N
Heart Disease	Y N	Stroke	Y N	High Blood Pressure	Y N

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a care program designed for me if determined to be clinically medically necessary by my doctor. I will notify them of any changes in my health status during the duration of the program. It is also my duty to daily inform the doctor or assistant of any possible complication prior to the initiation of my daily treatment.

Your signature ____ Date ________________

Physician signature _______________________________________ Date ________________