



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: \_\_\_\_\_

Marital 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 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	___
Diabetes	___	Hip Pain	___	Loss	___
Change in bowel or bladder function	___	Herniated Disc	___	Other: _____	___
		Arthritis	___		___

**Previous Injuries**

Injuries/surgeries you have had	Description	Date
Falls _____	_____	_____
Surgeries _____	_____	_____
Broken Bones _____	_____	_____
Car Accident _____	_____	_____
Hospitalizations _____	_____	_____
Allergies _____	_____	_____

**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 \_\_\_\_\_