



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? Y N

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

Previous Injuries

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

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: _____

Do you smoke? Y N 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: _____

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 _____