Complete Chiropractic

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:_____
Have you ever smoked? Y N Currently Packs/day:_____ Years:_____
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:_____
Anything help with the pain:_____
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 or MRIs? Y N If yes, date:_____
For what?_____
Medications: ❑ none: _____
_____
Supplements and brands:_____
Allergies: ❑ none: _____

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		Herniated Disc	___	Other:_____	
bladder function	___	Arthritis	___	_____	

Current of Former Major Illnesses or Injuries

	Description	Date
Major Illnesses	_____	_____
Surgeries/Broken Bones	_____	_____
Falls/Car Accidents	_____	_____
Hospitalizations	_____	_____
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:_____

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? *** indicate relationship**

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 _____