Today's Date: __________ Patient ID #: VRC_________

How did you hear about our office? ____

Demographic Information

Name ___________________________________ Nickname _________________ ☐ Male ☐ Female

Date of Birth _____ / _____ / ______ Age: ______ Marital Status: M S D W # Children _______

Address ___________________________ City __________________ State ______ Zip ____________

Cell Phone: ______________________ E-mail Address: _______________________________________

Occupation ___________________ Employer ______________________ Height ______ Weight______

Emergency Contact ______________________ Phone # ________________ Relation ______________

Health Insurance

Do you have Health Insurance? ☐ Yes ☐ No (Please present insurance card to front desk)

If the primary insured on the policy is different than the patient, please provide the following information for the PRIMARY INSURED:

Name: ____________________________ Date of Birth ___ / ___ / _____ ☐ Male ☐ Female

History of Complaint

What condition(s) brings you into the office: ____

Primary Complaint __________________________ Secondary Complaint ________________________

How long have you noticed the problem(s)? ____

Have you ever had this in the past? ____________________ If yes, when? _______________________

Other treatments tried? ________________________________ Provider? _______________________

When? __________________ Results were ☐ Favorable ☐Unfavorable Why ___________________

Please identify any other injuries/complaints to your body: ____________________________________

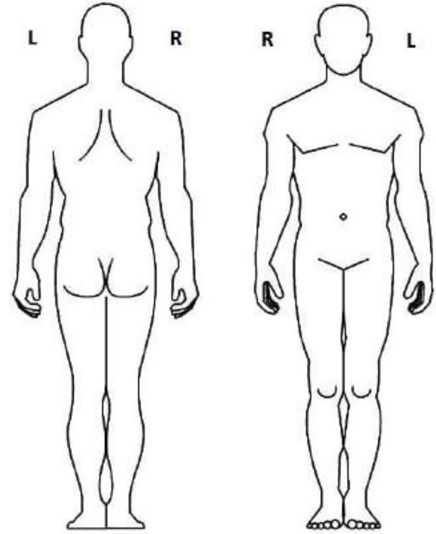
Is your condition the result of ANY type of accident? ☐ YES ☐ NO (If yes, see front desk)

Date of Accident _________________ Type of Accident ☐ Auto ☐ Work ☐ Home

Briefly describe accident ____

Please mark the areas on the diagram with the following letters to describe your symptoms:

R*= Radiating* ***B****= Burning* ***D****= Dull* ***S****= Sharp/Stabbing*
N*= Numbness* ***T****= Tingling* ***P*** *= Pins/Needles* ***A****= Ache*



How long does it last? ☐ Occasional *(0-25%)*
☐ Intermittent *(25-50%)*
☐ Frequent *(50-75%)*
☐ Constant *(100%)*

When is the problem worse? ☐ AM ☐ Afternoon ☐ PM

What relieves your symptom(s) __________________________

What makes your symptoms(s) worse _____________________

Past History

If you have ever experienced or been diagnosed with any of the following conditions, please indicate: **P** for **PAST**, **C** for **CURRENT**, or leave **BLANK** for **NEVER** have had.

___Headache
___Neck Pain
___TMJ/Jaw Pain
___Shoulder Pain
___Upper Back Pain
___Mid Back Pain
___Lower Back Pain
___Hip Pain
___Sciatica
___Carpal Tunnel
___Numb/Tingling Arm, Hand, Finger
___Numb/Tingling Leg, Foot, Toe

___Tremors/Seizures
___Trouble Sleeping
___Swollen/Painful Joints
___Heartburn/ulcers
___Back curvature
___Scoliosis
___Pain with cough/sneeze
___Sinus/Allergy Problems
___Dislocations
___Fractures

___Dizziness
___Depression
___Thyroid Problems
___Digestive Problems
___Blood Pressure Problems
___Gallbladder Trouble
___Kidney Trouble
___Heart Disease/Heart Attack
___Fibromyalgia
___Arthritis, Type: _____________________
___Pregnant (Now) Due Date: ____________
___Other______________________________

___AIDS/HIV
___Cancer
___Tumors
___Stroke
___Diabetes
___Asthma
___AD(H)D
___Hernia

Please list any past or current injuries or surgeries along with when they happened:

INJURIES: ____

SURGERIES: ____

Activities of Daily Living

Indicate which daily tasks are affected and the level of pain experienced:

No Pain (0), Tolerable Pain (3), Moderate Pain (5), Moderate-Severe Pain (7), Disabling Pain (10)

Bending___	Carrying___	Climbing___	Dancing ____	Doing Chores___
Computer Work___	Dressing___	Driving___	Gardening___	Lifting___
Sports/Exercise___	Pushing ____	Rolling over___	Running___	Sitting___
Sit to Stand___	Sleeping___	Standing___	Walking___	Watching TV___
Working___	Other____			

Social History

How many hours of sleep (on average) do you get per night? ____________

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes → How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcoholic Beverages: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Prescription/OTC Medications: ____

Vitamins/Supplements: ____

Family History

Does anyone in your family suffer with the same condition(s) you currently have? ☐ Yes ☐ No

If yes, who? ______________________

Any hereditary conditions the doctor should be aware of? ____

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous and can hinder treatment.

Patient Name: _______________________________

Patient Signature: _____________________________ Date: ____________

(OFFICE USE ONLY)

Vitals: Height ___________ Weight ___________ BP _____________ Pulse ____________

Systems review with patient: ☐ Musculoskeletal ☐ Neurological

Doctor's Signature: _______________________ Date Reviewed: ___________