FIELDS CHIROPRACTIC CLINIC

Date: _____

Patient Name _____ Cell Phone: _____ Cell Phone Carrier _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Race _____ Ethnicity _____
(i.e. Asian, Hispanic, White, etc.) (i.e. Latin, German, Korean, etc.)

Date of Birth _____ Age _____ Gender ___M ___ F Marital Status _____ # of Children _____

Primary Care Physician's Name, Address and Phone/Fax Number _____

_____

Referred to our office by : _____

Emergency Contact Name _____Phone Number _____Relationship _____

Please check all of the following that apply to you :

_____ Alcohol Use
_____ Drug Use (Non-Prescription)
_____ Tobacco Use If so, Type _____
_____ Diabetes
_____ High Blood Pressure
_____ Stroke (Date) _____
_____ Corticosteriod Use (Cortisone,Prednisone, etc.)
_____ Taking Birth Control Pills
_____ Dizziness/Fainting
_____ Numbness in Groin/Buttocks
_____ Cancer/Tumor (Explain) _____
_____

_____ Prostate Problems
_____ Menstrual Problems
_____Urinary Problems
_____ Currently Pregnant, # Weeks _____
_____ Abnormal Weight ___Gain ___Loss
_____ Marked Morning Pain/Stiffness
_____ Pain Unrelieved by Position or Rest
_____ Pain at Night
_____ Visual Disturbances, If so, explain _____
_____
_____ Osteoporosis
_____ Epilepsy/Seizures

Surgeries [list date(s) and procedure(s)] _____

_____

_____

Other Health Problems (i.e. allergies, etc.) _____

_____

_____

Medications (Name of drug and indicate condition being treated, or attach a copy of list)_____

_____

_____

_____

Family History

____ High Cholesterol (Mother)
____ High Cholesterol (Father)
____ Diabetes (Mother)
____ Diabetes (Father)
____ High Blood Pressure (Mother)
____ High Blood Pressure (Father)
____ Osteoarthritis (Mother)
____ Osteoarthritis (Father)

____ Heart Problems (Mother) Specify Condition _____
____ Heart Problems (Father) Specify Condition _____
____ Stroke (Mother)
____ Stroke (Father)
____ Rheumatoid Arthritis (Mother)
____ Rheumatoid Arthritis (Father)
____ Cancer (Mother) Specify Condition _____
____ Cancer (Father) Specify Condition _____

1ST AREA OF CONCERN:

DESCRIBE YOUR CURRENT PROBLEM: _____.

Is this? _____Work Related ___ Auto Related ___ N/A DATE PROBLEM BEGAN _____

HOW PROBLEM BEGAN: _____

HOW DO YOU FEEL TODAY ? (Circle one) **NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN**.

HOW OFTEN ARE YOUR SYMPTOMS PRESENT? (Circle one) **Occasional ___0-25% ___26-50% ___51-75% ___76-100%**

In the past week, how much has your pain interfered with your daily activities (i.e., work, social activities, or household chores)? (Circle one) **No interference 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities**.

Have you had x-rays, MRIs, or CT scans for this area of concern? ___Yes ___No Date taken: _____

2ND AREA OF CONCERN:

DESCRIBE YOUR CURRENT PROBLEM:_____.

Is this? _____Work Related ___ Auto Related ___ N/A DATE PROBLEM BEGAN _____

HOW PROBLEM BEGAN: _____

HOW DO YOU FEEL TODAY ? (Circle one) **NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN**.

HOW OFTEN ARE YOUR SYMPTOMS PRESENT? (Circle one) **Occasional ___0-25% ___26-50% ___51-75% ___76-100%**

In the past week, how much has your pain interfered with your daily activities (i.e., work, social activities, or household chores)? (Circle one) **No interference 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities**.

Have you had x-rays, MRIs, or CT scans for this area of concern? ___Yes ___No Date taken: _____

3RD AREA OF CONCERN:

DESCRIBE YOUR CURRENT PROBLEM: _____.

Is this? _____Work Related ___ Auto Related ___ N/A DATE PROBLEM BEGAN _____

HOW PROBLEM BEGAN: _____

HOW DO YOU FEEL TODAY ? (Circle one) **NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN**.

HOW OFTEN ARE YOUR SYMPTOMS PRESENT? (Circle one) **Occasional ___0-25% ___26-50% ___51-75% ___76-100%**

In the past week, how much has your pain interfered with your daily activities (i.e., work, social activities, or household chores)? (Circle one) **No interference 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities**.

Have you had x-rays, MRIs, or CT scans for this area of concern? ___Yes ___No Date taken: _____

MARK AN "X" ON THE DIAGRAM WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. PLEASE INDICATE NEXT TO "X" IF PAIN IS DULL ACHE, BURNING, NUMB/TINGLING, SHARP, STABBING, TIGHTNESS OR THROBBING.