WELCOME to Portage Chiropractic

808 Caldwell Avenue, Suite 102, Portage, PA 15946

Name____Today's Date ____/____/_____

Birth Date ____/_____/_____ Age _____ ☐ Male ☐ Female What you prefer to be called? _______________

Home Address ____

____

Home Phone ____

Cell Phone #____

OK to leave voice messages at these numbers? ☐ YES ☐ NO

How did you hear about our office? ____

Employer Name ____ Occupation___________________________________

Employer Address____ Work Phone__________________

IN EVENT OF EMERGENCY

Who should we contact? ____ Relationship______________________________

Home Phone _____________________________ Alternate Phone _____________________________

REASON FOR VISIT

Have you been treated by a chiropractor before? ☐ YES ☐ NO If so, when? _________________________________

CHIEF Complaint____ Date these symptoms began ____/_____/_____

SECONDARY Complaint____ Date these symptoms began ____/_____/_____

How severe is your pain? ☐ Intolerable ☐ Severe ☐ Moderate ☐ Mild

Are your symptoms: ☐ Auto Accident Related ☐ Work Accident Related ☐ Neither

HOW did the symptoms start? ☐ Slip/Fall ☐ Lifting ☐ Sleeping Wrong ☐ Repetitive Strenuous Activity ☐ Bending ☐ Twisting ☐ Turning ☐ Yard Work ☐ Housework ☐ Sports Activity ☐ Other____________________________

How often do you experience symptoms? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Infrequently ☐ Intermittently

What makes your symptoms better? ____

What makes your symptoms worse? ____

HEALTH HISTORY

Have you had any of the following medical condition(s)? **Answer *EVERY* question by circling Y or N:**

MUSCULOSKELETAL	Y N Heart Surgery/ Pacemaker	Y N Difficulty Breathing
Y N Low Back Problems	Y N Mitral Valve Prolapse	Y N Emphysema
Y N Artificial Bones/Joints	Y N Heart Murmur	EYES
Y N Frequent Neck Pain	Y N Artificial Valves	Y N Cataracts/Glaucoma
Y N Arthritis	Y N High/Low Blood Pressure	ENM&T
NEUROLOGICAL	PSYCHIATRIC	Y N Sinus Problems
Y N Fainting/Seizures/Epilepsy	Y N Psychiatric Problems	GASTROINTESTINAL
Y N Severe/Frequent Headaches	ENDOCRINE	Y N Hepatitis
Y N Shingles	Y N Diabetes	Y N Ulcers/Colitis
CARDIOVASCULAR	Y N Kidney Problems	HEMOTOLOGIC/LYMPHATIC
Y N Heart Attack/Stroke	RESPIRATORY	Y N Anemia
Y N Congenital Heart Defect	Y N Asthma	Y N Easy Bruising

Please list other serious medical condition(s) (e.g. Cancer):____

____

List **previous** surgeries/treatments with dates:____

____

List any past **serious** accidents with dates:____

Do you smoke? ☐ Never Smoker ☐ Former Smoker ☐ Daily Smoker ☐ Occasional Smoker

Do you exercise with moderate activity at least 3 times per week? ☐ Yes ☐ No

Are you wearing? ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

WOMEN: Are You Pregnant? ☐ No ☐ Yes How Long? ____________________

In the event that you would need our office to communicate your healthcare information to another person, to whom may we do so?

Spouse: ____
(name) (address) (phone)

Children: ____
(name) (address) (phone)

Others: ____
(name) (address) (phone)

Any limitations on issues this person or persons may discuss? ☐ No ☐ Yes If Yes, please specify (example: claims payment, co-payment, treatment plans, etc.) ____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE____ **DATE** _____ / ______ / ______