collins chiropractic
You were born to be healthy.

Welcome to our office! Please let us know if there is anything we can do to make your visit a most pleasant experience.

Patient Information

Name: _____ Date: _____ Date of birth: _____
Street address: _____ City: _____
State: _____ Zip code: _____ Home phone: _____
Cell phone: _____ Cell phone provider (for text reminders): _____
Email address: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Spouse's name: _____
# of children: _____
Occupation: _____ Employer: _____
Emergency contact name / Phone: _____ / _____
Whom may we thank for referring you? _____

Insurance provider: _____ Prefix and ID#: _____
Group #: _____ Eff. Date: _____ Subscriber name: _____
Relationship to subscriber: _____ Subscriber date of birth: _____

Health Information

What is the reason for your visit? ☐ Wellness ☐ Physical Complaint ☐ Accident ☐ Other
*If you checked Wellness, please proceed directly to the Lifestyle section (page 3)

1. Please circle any of the following physical complaints you have:

Left shoulder pain
Left arm pain
Left wrist pain
Radiating pain into left shoulder
Radiating pain into left arm
Numbness/Tingling to left hand

Left sacrum-iliac pain (tailbone)
Left hip pain
Left leg pain
Left knee pain
Left foot pain
Numbness/tingling to left foot

Right shoulder pain
Right arm pain
Right wrist pain
Radiating pain into right shoulder
Radiating pain into right arm
Numbness/Tingling to right hand

Right sacrum-iliac pain (tailbone)
Right hip pain
Right leg pain
Right knee pain
Right foot pain
Numbness/tingling to right foot

Headaches
Neck pain
Neck stiffness

Mid back pain
Mid back stiffness

Low back pain
Low back stiffness

Other: _____
_____
_____

2. When did your symptoms begin? _____

3. What was the mode of onset?

Not doing anything
Overextending
Lifting an object

Motor vehicle accident
Work Injury
In strenuous position

Fell
Other: _____

4. How soon did the symptoms come on?
Immediately Few hours later Next Day Few days later About a week later Other: _____

5. Have you experienced these symptoms before? ☐ Yes ☐ No

6. When do you first remember experiencing these symptoms? _____

7. What seems to increase the symptoms?
Nothing Coughing Bending Reaching Sitting Standing Lifting
Pulling Stretching Walking Turning Other: _____

8. What seems to diminish the symptoms?
Nothing Rest Sitting Ice Heat Medication Exercise Standing Other: _____

9. How would you characterize the pain?
Burning Dull Sharp Aching Throbbing Shooting Other: _____

10. Does your pain radiate to any of the following areas? ☐ Yes ☐ No
Left shoulder Left arm Left hand Left buttock Left leg Left foot
Right shoulder Right arm Right hand Right buttock Right leg Right foot

11. Are you experiencing any numbness/tingling in the following areas? ☐ Yes ☐ No
Left shoulder Left arm Left hand Left buttock Left leg Left foot
Right shoulder Right arm Right hand Right buttock Right leg Right foot

12. Please rate your average level of pain on a scale of 0-10 (0=no pain, 10=worst pain ever)
1 2 3 4 5 6 7 8 9 10

13. When are the symptoms worst?
☐ Morning ☐ Afternoon ☐ Evening ☐ While Sleeping ☐ While Awake

14. When are the symptoms best?
☐ Morning ☐ Afternoon ☐ Evening ☐ While Sleeping ☐ While Awake

15. Have you seen anyone else for this complaint?
☐ None ☐ Chiropractor ☐ Physical Therapist ☐ Specialist ☐ Other: _____
Name of provider: _____

16. What happened to your condition as a result of treatment?
Resolved Unresolved Improved but not to acceptable level Worsened

17. Please list any drug allergies: _____

18. Do you have a history of any of the following?
Work related injury Motor vehicle accident Slip and fall accident

If yes, please list approximate dates and incidents:
Incident: _____ Date: _____
Incident: _____ Date: _____
Incident: _____ Date: _____
Incident: _____ Date: _____

19. Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please list approximate dates and condition:
Condition: _____ Date: _____
Condition: _____ Date: _____
Condition: _____ Date: _____
Condition: _____ Date: _____

20. Have you had any surgeries? ☐ Yes ☐ No

If yes, please list approximate dates and surgery:
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____

Lifestyle Information

1. How would you rate your overall health? (1=poor, 10=excellent)
1 2 3 4 5 6 7 8 9 10

2. Do you have any of the following symptoms?

Headaches	Anxiety	Excessive vomiting	Chills
General fatigue	Hearing trouble	Loss of sleep	Fainting
Night sweats	Pain in eyes	Dizziness	Phobias
Nervousness	Nose bleeds (chronic)	Depression	Pain in ears
Mood swings	Bleeding gums	Ringing in ears	Nose/sinus pain
Vision trouble	Tonsillitis	Eye discharge	Absence of smell
Excessive drainage	Goiter	Nasal infections	Absence of taste
Mouth sores	Skin itching	Enlarged glands	Heat/cold intolerance
Abnormal taste	Bruise easily	Difficulty swallowing	Skin rash
Sugar in urine	Swollen extremities	Tremors	Eczema
Redness of skin	Chest pain	Weight change	Hair changes
Nail changes	Prostate problems	Convulsions	Chronic wheezing
Difficulty breathing	Bed-wetting	Memory loss	Varicose veins
Rapid heartbeat	Sterility	Skin dryness	Heart murmur
Decreased appetite	Abnormal vaginal bleeding	Chronic cough	Hemorrhoids
Excessive gas	Impotence	Blue extremities	Excessive constipation
Heartburn/indigestion	Breast pain	Heart palpitations	Ear discharge
Frequent urination	Redness/itching of breast	Abdominal pain	
Painful menstruation	Dimpling of breast	Excessive diarrhea	
Lumps in breast	Discharge from breast	Painful urination	
Weakness fever	Increased appetite	Irregular menstruation	

3. Please rate the importance for you to do the following: (1=not important, 10 = necessary)

Exercise 1 2 3 4 5 6 7 8 9 10
Eat right 1 2 3 4 5 6 7 8 9 10
Reduce stress 1 2 3 4 5 6 7 8 9 10
Stop smoking 1 2 3 4 5 6 7 8 9 10
Get off medication 1 2 3 4 5 6 7 8 9 10
Reduce pain 1 2 3 4 5 6 7 8 9 10
Increase mobility 1 2 3 4 5 6 7 8 9 10
Improve body's function 1 2 3 4 5 6 7 8 9 10
Improve posture 1 2 3 4 5 6 7 8 9 10
Increase energy 1 2 3 4 5 6 7 8 9 10
Improve sleep 1 2 3 4 5 6 7 8 9 10
Have a healthy family 1 2 3 4 5 6 7 8 9 10
Live an optimal life 1 2 3 4 5 6 7 8 9 10
Learn about wellness 1 2 3 4 5 6 7 8 9 10
Other: _____

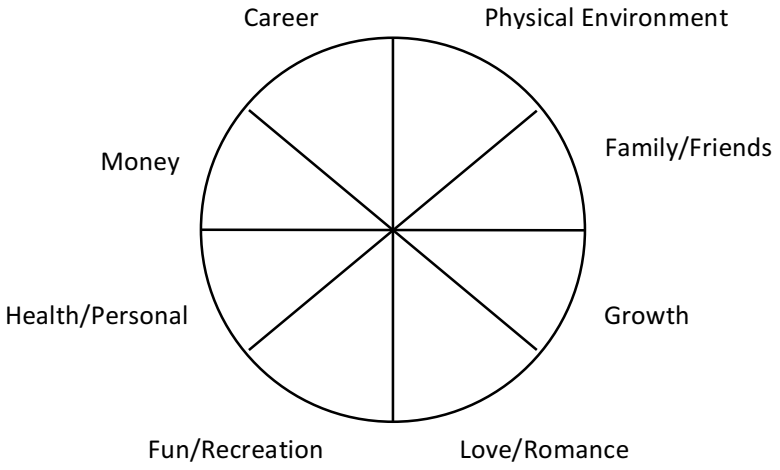
4. What are you currently doing to improve your health and wellness?

_____
_____

5. What are some of your current health goals?

_____
_____

6. Wellness is a balance of many factors.
Starting in the center, color in your level of satisfaction in the following areas:



The best investment you can make is to invest in your health. Thanks for letting Collins Chiropractic be part of your journey toward wellness!

Signature: _____ Date: _____