Joslyn Chiropractic Center

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Patient Information:

Today's Date ____________

Name: ____ S/S# ______________________
First Middle Last

Address: ____
Street City State Zip Code

Sex: Male ____ Female____ Birth Date _____/_____/_____ Age: __________

Home Phone: _____________________ Work Phone: ___________________ Cell Phone: ___________________

E-Mail: _________________________________ Your Employer _________________________
Occupation _________________________

Are you: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____ # of children you have _____
(If minor, Parent's name and number ____)

How did you hear about us: Phone Book _____ Internet yellow pages ____ Advertising sign____ Our Website_____
LBN _______ Insurance Company____ UAW Luncheon _______ Brochure_____ Other_____
Friend/Family____ If so, who ____________________________

Why did you choose our office? ____

Who should we contact in case of an emergency? ____

Relationship to you? _____________________________________ Phone: _________________________

Symptoms

Reason for visit _____________________________________When did you first notice the symptoms? ___________

Where specifically is the problem(s) located? 1.________________ 2. __________________ 3. _________________

Which types of activities are difficult to perform? Sitting____ Standing ____Walking ____Bending ____Lying down _____

What type of pain are you having? Sharp ____ Dull ____ Throbbing _____ Numbness _____ Aching _____ Shooting _____
Burning _____ Tingling _____ Cramps _____ Stiffness _____ Swelling _____ Other ______________________________

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain or discomfort) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ___________________ is this condition getting progressively worse _______

Have you received any treatment for this condition? Medication ____ Surgery ____ Physical Therapy ____ Other ________

Name and number(s) of other doctor(s) who have treated you for your condition ________________________________

Please list any accidents and/or injuries you may have had and year of occurrence

____ ______________________________________
____ ______________________________________
____ ______________________________________

Please list any surgeries you may have had (with dates)

____ ______________________________________
____ ______________________________________
____ ______________________________________

Have you had previous chiropractic care? Yes ____ No ____ If yes, who and when ______________________________