Taylor Family CHIROPRACTIC

74 Main St. | Medway, MA 02053 Record # _____

Name _____ **Today's Date**_____ **Birthdate** _____ **Age**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Occupation** _____ **Gender** ❑ **M** ❑ **F**

E-Mail _____ **# of Kids/Ages** _____

Spouse name _____ **Emergency Contact** _____ **Phone Number** _____

Who May We Thank For Referring You To Our Office?:_____

PRESENT COMPLAINTS

Please fill out in as much detail as possible

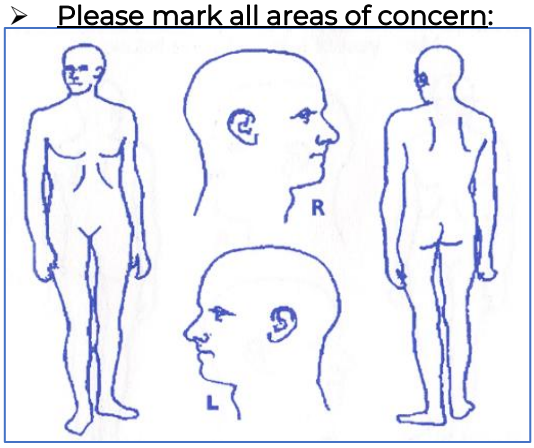
1._____ **How long has this been an issue?** _____

- **TIMING:** ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%)
- **WORSE AT**: ❑ Morning ❑ Mid-day ❑ Night ❑ Varies
- **FEELS LIKE:** ❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other _____
- **DOES IT RADIATE?** ❑ No ❑ Yes, to:_____
- **IT IS:** ❑ Staying the same ❑ Getting worse ❑ Improving
- **PAIN SCALE (right now as you fill this out):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **PAIN SCALE (when it is at its worst):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **RELIEVED BY:** _____ **AGGRAVATED BY:** _____
- **PREVIOUS EPISODES:** ❑ No ❑ Yes; details:_____
- **PREVIOUS CARE FOR THIS CONDITION?** ❑ No ❑ Yes: _____
- **RECENT TESTING?** ❑ No ❑ Yes: _____

2._____ **How long has this been an issue?** _____

- **TIMING:** ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%)
- **WORSE AT**: ❑ Morning ❑ Mid-day ❑ Night ❑ Varies
- **FEELS LIKE:** ❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other _____
- **DOES IT RADIATE?** ❑ No ❑ Yes, to:_____
- **IT IS:** ❑ Staying the same ❑ Getting worse ❑ Improving
- **PAIN SCALE (right now as you fill this out):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **PAIN SCALE (when it is at its worst):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **RELIEVED BY:** _____ **AGGRAVATED BY:** _____
- **PREVIOUS EPISODES:** ❑ No ❑ Yes; details:_____
- **PREVIOUS CARE FOR THIS CONDITION?** ❑ No ❑ Yes: _____
- **RECENT TESTING?** ❑ No ❑ Yes: _____

- Please mark all areas of concern:



Any other information the doctor should know:

_____

_____

_____

DOCTORS NOTES: _____

_____

_____

Patient/Guardian Signature _____ Date _____ Doctor Signature _____ Date _____

Taylor Family CHIROPRACTIC

74 Main St. | Medway, MA 02053 Record # _____

Patient Name_____ **Date** _____

PATIENT HISTORY

❑ **NO MEDICAL PROBLEMS - No prior history of any significant medical problems: (Please Initial:)** _____

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use Packs Daily_____ for ____years
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes; Type _____	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Lung/Respiratory Conditions _____
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke/TIA History _____
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems _____
❑	❑	Vision Problems	❑	❑	Men: Prostate conditions _____
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems _____
❑	❑	Other _____			
❑	❑	Cancer (please give details):_____			

****WOMEN ONLY**

Experience painful menstrual cycles: ❑ Yes ❑ No **| Have Irregular Cycle:** ❑ Yes ❑ No **| Breast Implants:** ❑ Yes ❑ No

Are you pregnant: ❑ Yes ❑ No **| Are you Nursing:** ❑ Yes ❑ No **| Are you on birth control:** ❑ Yes ❑ No

Current Medications: ❑ NONE

_____

_____

Past Injuries (Include auto collisions and work injuries) and treatment received: ❑ NONE

_____

_____

Past Hospitalizations and surgeries: PLEASE LIST ANY MEDICAL OR SURGICAL IMPLANTS ❑ NONE

_____

_____

FAMILY HISTORY

❑ No known significant family history

❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Blood Disorders ❑ Neurological Problems ❑ Arthritis ❑ Other, explain:

_____

Is there any other significant family history? _____

Patient/Guardian Signature _____ Date _____ Doctor Signature _____ Date _____