Stinnett Chiropractic

"we correct pinched nerves"

Date:_____

First Name:_____**Last Name:**_____

Address:_____

City:_____**State:**_____**Zip:**_____

Home Phone:_____**Cell Phone:**_____

Gender: Male Female

Birth Date:_____ **Marital Status: Single Married Divorced Widowed**

Email Address:_____

Spouse Name:_____

Number of Children:_____**Names:**_____

Employer:_____**Occupation:**_____

Employer Phone Number:_____

Emergency Contact Information:_____

Phone Number:_____**Relationship:**_____

Reason for visit today?_____

How did you hear about us?_____

Have you seen other doctor(s) for this condition? YES NO

If yes when?_____

Prior Interventions (circle all that apply)

Acupuncture Chiropractic Heat Homeopathic Ice

Massage Medication OTC Meds Physiotherapy Surgery Other_____

What is the condition related to? (Circle one)

Auto Accident Home Injury Sports Injury Work Injury

Other:_____

When did the problem first start?_____

Have you had this condition before? YES NO
If yes, when?_____

Does the pain radiate or travel to other parts of the body? YES NO
If yes,
where?_____

Does anyone from your family suffer the same condition? YES NO
If yes,
who?_____

What makes the condition worse? (Circle all that apply)

Bending Lifting Coughing Sitting Standing Sneezing

Stairs Walking Other:_____

What makes the condition better? (Circle all that apply)

Rest Heat Ice Massage Medication

Other:_____

Does the condition affect employment? YES NO
If yes, how?_____

Does this condition affect recreation? YES NO
If yes, how?_____

Does this condition affect household activities? YES NO
If yes, how?_____

Does this condition affect your personal life? YES NO
If yes, how?_____

Does the condition affect sleep? YES NO
If yes, how?_____

If you did not have this issue, what would you do more of?_____

If you did nothing about it, what do you think would happen?_____

What else should we know about your condition?_____

Have you had an x-ray in the last six months? YES NO

I realize that x-ray examinations may be hazardous to an unborn child.
I certify to the best of my knowledge I am not pregnant. YES NO

Rate the severity of your pain from 0 to 10 (circle one)

0 1 2 3 4 5 6 7 8 9 10

No pain Excruciating Pain

Pain Duration (circle one)

Constant Frequent Intermittent Occasional

Current Medications (circle all that apply)

Blood Pressure Insulin Muscle Relaxer Nerve Pills Pain Meds

Other:_____

Musculoskeletal (circle all that apply)

Osteoporosis Back Problems Knee Injury Arthritis Hip Disorders Foot/Ankle Problems

Scoliosis TMJ Issues Shoulder Problems Neck Pain Poor Posture

Neurological (Circle all that apply)

Anxiety Headaches Dizziness Depression Numbness Pins & Needles

Cardiovascular (Circle all that apply)

High Blood Pressure Poor Circulation High Cholesterol Low Blood Pressure Chest Pain

Respiratory (Circle all that apply)

Asthma Shortness of Breath Emphysema Apnea Pneumonia Allergies

Digestive (Circle all that apply)

Anorexia/Bulimia Constipation Food Sensitives Ulcer Diarrhea Heartburn

Sensory (Circle all that apply)

Blurred Vision Nose Bleed Chronic Ear Infection Ringing in Ear Sore Throat

Loss of Smell Loss of Hearing

Integumentary (Circle all that apply)

Skin Cancer Rash Acne Psoriasis Bruise Easily Hair Loss

Eczema Slow Healing

Endocrine (Circle all that apply)

Thyroid Issues Swollen Glands Low Blood Sugar Immune Disorder Low Energy

Genitourinary (Circle all that apply)

Kidney Stones Prostate Issues Bedwetting Infertility PMS Symptoms

General (Circle all that apply)

Fainting Loss of Appetite Sudden Weight Gain Fatigue Loss of Sleep

Weakness Sudden Weight Loss

Personal Illness History (Circle all that apply)

Aids	Alcoholism	Allergies	Arteriosclerosis	Cancer	Chicken Pox
Diabetes	Epilepsy	Glaucoma	Goiter	Gout	Hear Disease
Hepatitis	HIV Positive	Malaria	Measles	Mult. Sclero.	Mumps
Polio	Pneumatic Fever	Scarlet Fever	STD	Stroke	Tuberculosis
Thyroid	Ulcer	Other:_____			

Surgical History (circle all that apply)

Cancer Back Surg. Bypass Surg. Hernia Other:_____

Fractures	Yes	No
Auto Accident	Yes	No
Spinal Surgery	Yes	No
Hospitalization	Yes	No

If yes, why?_____

How committed are you to achieving your maximum health potential?
(Circle one)

0 1 2 3 4 5 6 7 8 9 10
Not Interested Very Interested

How do you want us to handle your problem?
(Circle one)

Temporary Relief Max Correction

<u>Please read the following carefully before signing</u>.

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom and power. Our only method is a specific chiropractic adjustment to correct vertebral subluxations: which interfere with the body's wisdom and power. We believe that the greatest Doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

Signature_____Date_____