Cromwell Family Chiropractic

PATIENT INTRODUCTION

Date_____ **Case #**_____

Name_____ Nickname_____
Address_____ City_____ State_____ Zip_____
Cell Phone_____ Land Line_____ Work Phone_____
Sex: M F Marital Status: S M D W Birth date_____/_____/_____ Soc. Sec. #_____
How did you hear about our clinic? _____ Employer_____
Emergency Contact Name: _____ **Phone #**_____

APPOINTMENT REMINDERS AND OFFICE CORRESPONDENCE:

By filling out this section, you give us consent to contact you by text and email.

Cell Phone Number: _____
E-mail address _____

PRESENT COMPLAINT

Briefly describe Symptoms:_____

Other doctors seen for this condition:_____ Treatment rendered:_____

List any and all medications that you are **currently taking** or have taken **in the last 3 months**:

Medication	*Last Taken*	*Medication*	*Last Taken*

List Physicians seen within the last year:	*For what conditions:*

List all surgeries:	*When?*	*Surgery:*	*When?*

Are you pregnant? ☐ Yes ☐ No Date of last Menstrual Period:_____
Are you diabetic? ☐ Yes ☐ No

INSURANCE INFORMATION (Please provide front desk with copies of your cards)

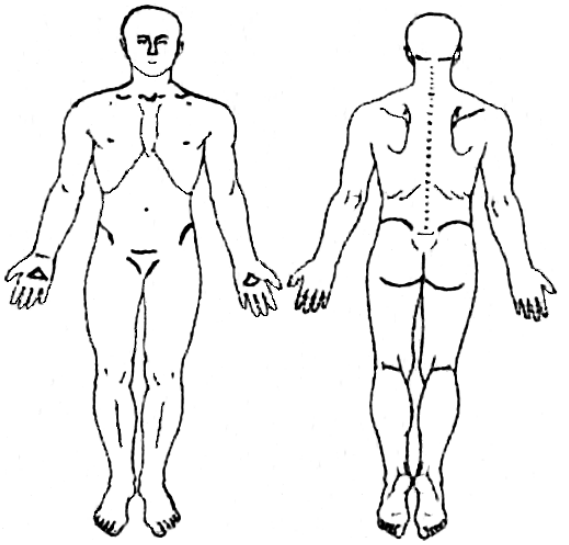
Insured's Full Name_____ Soc. Sec. #_____
Address (If different from pt.) _____ City_____
State_____ Zip_____ Home Phone_____ Insured's DOB_____
Relationship to insured: Self Spouse Child Other_____
Insurance Company_____ Phone #_____

Additional Insurance (2nd Policy)
Insured's Full Name_____ Soc. Sec. #_____
Relationship to insured: Self Spouse Child Other_____ Insured's DOB_____
Insurance Company_____ Phone #_____

FEES PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE

CONSULTATION

Mark the areas on your body where you feel the Described sensations. Use the appropriate symbol to mark all affected areas.



NUMBNESS " " "
BURNING x x x
STABBING / / /
PINS & NEEDLES 0 0 0

NAME_____

DATE_____CASE #_____

MAJOR COMPLAINTS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How did this condition develop? _____
_____

Any accidents, falls, etc. that might have caused your problem? _____
When was the very first time you experienced these symptoms? _____
Have you previously experienced this type of condition? _____
Have you received any treatment for this condition? _____
Has this problem been getting better, worse, or staying the same? _____
Is there anything you do that makes your condition worse? _____
How has this condition affected your:

A. Home life _____
B. Occupational life _____
C. Recreational activities _____
D. Rest and Sleep _____

Have you ever been in an automobile accident? Past year: _____ Past 5 years: _____Over 5 years:_____Never:_____
Have you ever seen another doctor for this problem? _____
Are you currently taking any medication? (also: aspirin, birth control pills, etc.) _____
Any chiropractic consulted in the past? Name: _____
Date consulted: _____ For what problem: _____

CURRENT OR PREVIOUS SYMPTOMS

Indicate current symptoms with "C" and previous symptoms with "P"

HEADACHE	NUMBNESS IN FINGERS, ARMS, LEGS	DIGESTIVE DISORDERS	EXTREME FATIGUE
HEAD SEEMS TOO HEAVY	CHEST PAIN	NAUSEA, VOMITING	SHORTNESS OF BREATH
LOSS OF MEMORY	EYE STRAIN	DIARRHEA	PAIN RADIATING INTO
EQUILIBRIUM PROBLEMS	PAIN BEHIND EYES	CONSTIPATION	* ARM Right / Left
DIZZINESS	EYES SENSITIVE TO LIGHT	DIFFICULTY IN EXCESSIVE LIFTING	* BOTH
FAINTING	EARS BUZZING / RINGING	* LIGHT / MODERATE	* LEG Right / Left
TREMORS / PALPITATION	LOSS OF TASTE / SMELL	* HEAVY	* BOTH
NECK PAIN / STIFFNESS	SINUS TROUBLE	* REPETITIVE	* NECK
NECK MOTION RESTRICTED	EXTREME NERVOUSNESS	DIFFICULTY IN EXCESSIVE	* BASE OF SKULL
UPPER BACK PAIN / STIFFNESS	TENSION / IRITABILITY	* STANDING	* SHOULDER
MID BACK PAIN / STIFFNESS	ANXIETY / DEPRESSION	* WALKING	* HIPS
LOW BACK PAIN / STIFFNESS	INSOMNIA	* RIDING	
PINS & NEEDLES IN ARMS / LEGS	EXCESS PERSPIRATION	* BENDING	