

Date of Birth _____ Age _____ Social Security # _____
 Last _____ First _____ Middle Initial _____
 Address _____ City _____ ST _____ Zip _____
 Phone (H) _____ (W) _____ (C) _____
 Email _____ May we send you our online newsletter or Health Updates? yes no
 Your Occupation _____ Employer _____
 Spouse's Name _____ Spouse DOB _____ Spouse SSN: _____
 Primary Care Physician _____ Location _____
 Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you smoke? yes no If yes, how many packs per week? _____

Have you ever smoked in the past? yes no If yes, when did you quit? _____

Do you take birth control? yes no Have you ever taken birth control in the past? yes no

Do you consume alcohol? yes no If yes, how many drinks per week? _____

Do you consume caffeine? yes no If yes, how many drinks per day? _____

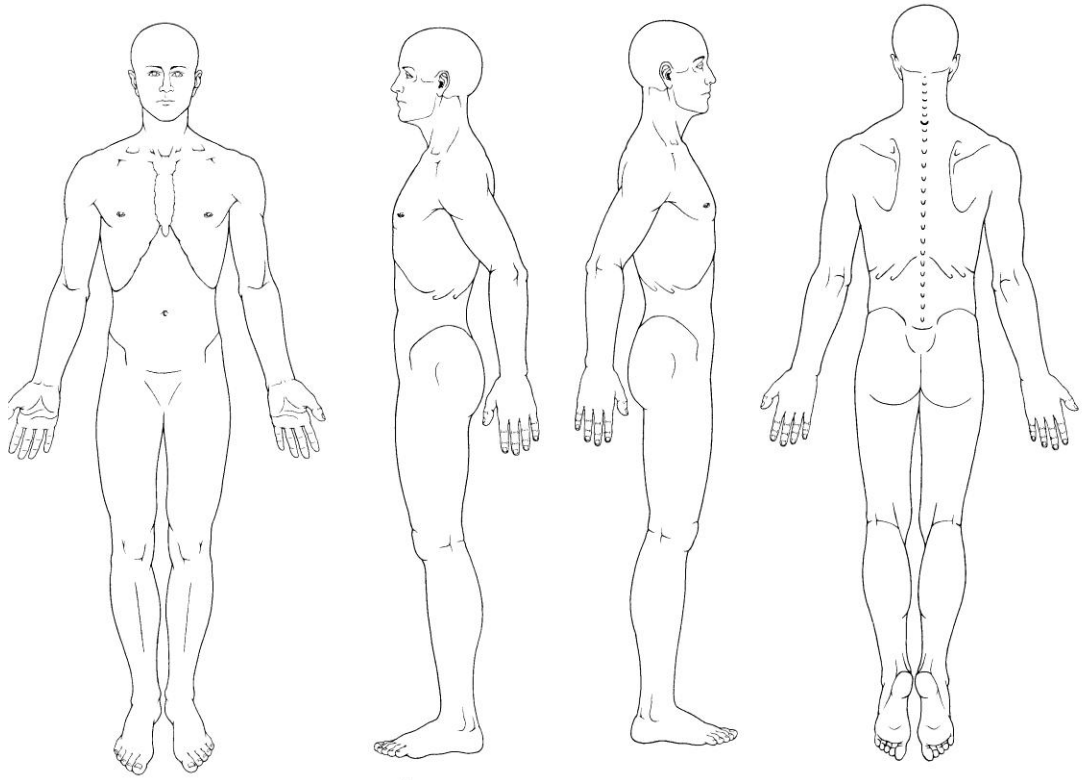
Do you exercise? yes no If yes, how many times per week and what type? _____

Do you have a high stress level? yes no If yes, list reasons: _____

Please list any medications or vitamins you are currently taking:

PATIENT SIGNATURE _____ DATE _____

Please mark off the areas of your complaint on the diagram above with the following indicators:
 PPP = pain
 NNN = numbness
 TTT= tingling
 BBB= burning
 CCC= cramping
 XXX = other



Please list all previous medical diagnosis, surgeries, injuries, accidents, falls, etc: _____

WELCOME

The doctor and staff of **Carolina Spine & Sports** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

ACCEPTANCE AS PATIENT

I understand and agree that the doctor of **Carolina Spine & Sports** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

PATIENT SIGNATURE _____ DATE _____