Welcome

Crouch FAMILY CHIROPRACTIC

Patient Information	Today's Date:

Birth Date:_____ Sex: ☐ Male ☐ Female SSN_____

Last Name _____ First Name _____ Middle Initial _____Nickname _____

Address: _____ City: _____ State: _____ Zip _____

Phone # (Best to Reach You): _____Phone (Other): _____Email:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation _____

Referred By _____Spoken Language:_____ Race:_____ Ethnicity:_____

Emergency Contact_____Phone Number: _____Would you like to receive our newsletter? ☐ Yes ☐ No

Number of Children _____ Names & Ages _____

Method of Payment: (Please circle) Insurance, Self Pay, Care Credit, Med-pay, Other _____

Have you ever had chiropractic care before? **Y / N** For what problem _____ Were the results satisfactory? **Y / N**

When was the last time you had spinal x-rays or MRI?_____ Primary Doctor:_____ OB/GYN:_____

The reason I am here is because I want: **(Please check below all that apply)** Females: Are you pregnant? Yes / No / I don't know

☐ Relief ☐ Corrective Care ☐ To be healthy ☐ I want the Doctor to recommend what is best for my health condition

We want you to have your "Summary of Patient Health Information"
This is specific information about your health history and keeps you up to date on what we have on file for you.
You will get one email with a secure link to our software. Use this link anytime you want to access your health information.
Please make sure we have your email address (above).
You will need a password to access your account. This will be your last name (lowercase) + last 4 digits of SS# _____

Any Surgeries	Trauma History	Current Meds	Allergies	Exercise	Social History
	Car Accidents	Please list your medications and dosage.	List any allergies and Severity. (Mild, Mod, Sev)	Do You Exercise? ☐ Yes ☐ No	**Please Check One:**
				If yes, what kind?	Current Smoker ___
					Former Smoker ___
					Never Smoked ____
Implants	Serious Illnesses			How Often?	Smokeless Tobacco (Dip or Chew) ☐ Yes ☐ No
					Caffeine ☐ Yes ☐ No
Broken Bones	**Please list your Vitamins**			Other Hobbies	Alcohol ☐ Yes ☐ No

Family History:

Did / Does your Mother (M) or Father (F) have any of the following?

☐ High Blood Pressure (M / F)	☐ Heart Attack (M / F)	☐ Emphysema (M / F)	☐ Seizures – Convulsions (M / F)
☐ Asthma (M / F)	☐ Diabetes (M / F)	☐ Kidney Disease (M / F)	☐ Pace Maker (M / F)
☐ Ulcers (M / F)	☐ Arthritis (M / F)	☐ Stroke (M / F)	☐ Digestive Troubles (M / F)
☐ Mental Illness (M / F)	☐ Thyroid (M / F)	☐ Cancer (M / F)	☐ Osteoporosis (M / F)

Please list any other health challenges / problems in your family history:

_____

_____

Patient Initials: **Date:** / / **VRC#**

Have you had or do you have any of the following symptoms which are or have been significant distress to you? Please indicate with the letter **N** if you have these conditions NOW (within the past 12 months) or **P** if you have ever had this conditions in the past (a year or longer). Leave blank if it has never been affected.

	Now N	Past P
Headaches		
Neck Pain		
Stiff Neck		
Sleeping		
Back		
Nervousness		
Tension		
Irritability		
Chest Pains		
Dizziness		
Shoulder/Neck/Arm Pain		
Pins & Needles in Arms		
Pins & Needles in Legs		
Numbness in Fingers		
Numbness in Toes		
High Blood Pressure		
Difficulty Urinating		
Allergies		
Weakness in Arms		
Weakness in Legs		
Shortness of Breath		
Fatigue		
Depression		
Lights Bother Eyes		
Loss of Memory		
Ears Ring		
Face Flushed		
Buzzing in Ears		

	Now N	Past P
Frequent Loss of Balance		
Fainting		
Loss of Smell		
Problems / Loss of Taste		
Diarrhea with Pain		
Feet Cold		
Hands Cold		
Arthritis		
Muscle Spasms		
Frequent Colds		
Stomach Upset		
Constipation		
Cold Sweats		
Fever		
Sinus Problems		
Diabetes		
Hemorrhoids		
Leg Cramps		
Colitis		
Gall Bladder		
Indigestion		
Belching		
Vomiting		
Shoulder Pain		
Swelling Joints		
Knee Pain		
Hayfever		
Menstrual Difficulties		

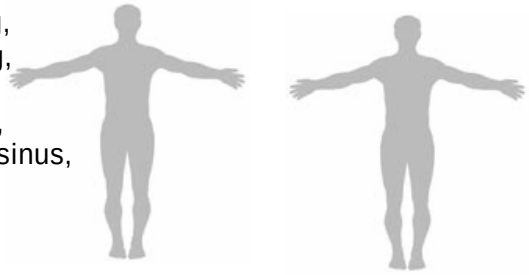
Activities of Daily Living:

Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Sleeping:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Running:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Climbing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Carrying:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Pushing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Reading:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Watching TV:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Doing Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Gardening:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Playing Sports:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Working:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Dancing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Change Positions: (Sitting to Standing)	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Rolling Over:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Other: _____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)

Please Fill Out the Information Below and Circle ALL that Apply to the Problems You Experience

Patient Initials:
Date: / / VRC#

Main Health Concern #1) _____

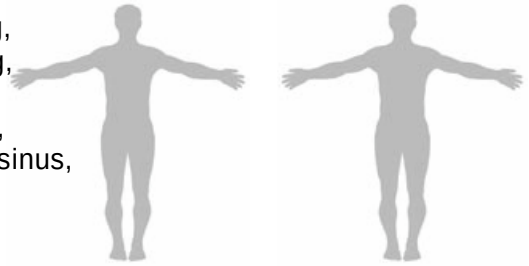
Onset Date	Type:	Quality	Location	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,	Front / Back	Constant,	Mild,
Exacerbated	Swelling	throbbing, crushing,		Frequent	Tolerable ,
	Muscle Spasms	stabbing, local,		Intermitt	Moderate ,
	Headache	radiating, migraine,		Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,		Infrequent	Disabling
	Stiffness	Other		% Awake	
	Tingling, Weakness			Time____	

What Caused the Problem? _____ Does it Radiate? Yes No

What Makes it: WORSE?_____ Better?_____

OFFICE USE: _____

Main Health Concern #2) _____

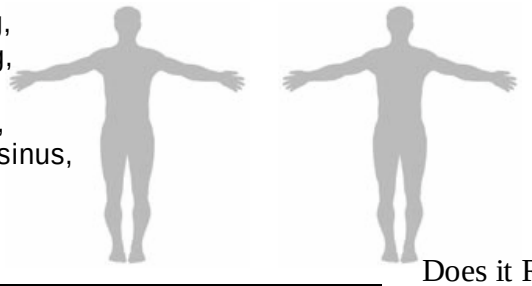
Onset Date	Type:	Quality	Location	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,	Front / Back	Constant,	Mild,
Exacerbated	Swelling	throbbing, crushing,		Frequent	Tolerable ,
	Muscle Spasms	stabbing, local,		Intermitt	Moderate ,
	Headache	radiating, migraine,		Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,		Infrequent	Disabling
	Stiffness	Other		% Awake	
	Tingling, Weakness			Time____	

What Caused the Problem? _____ Does it Radiate? Yes No

What Makes it: WORSE?_____ Better?_____

OFFICE USE: _____

Main Health Concern #3) _____

Onset Date	Type:	Quality	Location	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,	Front / Back	Constant,	Mild,
Exacerbated	Swelling	throbbing, crushing,		Frequent	Tolerable ,
	Muscle Spasms	stabbing, local,		Intermitt	Moderate ,
	Headache	radiating, migraine,		Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,		Infrequent	Disabling
	Stiffness	Other		% Awake	
	Tingling, Weakness			Time____	

What Caused the Problem? _____ Does it Radiate? Yes No

What Makes it: WORSE?_____ Better?_____

OFFICE USE: _____

ANY Other Health Concerns? _____

OFFICE USE: