COLUMBIA RIVER
— CHIROPRACTIC —

WELCOME

PATIENT INFORMATION

Date ____________ SS/HIC/Patient ID# ____________

Patient Name ____________ (Last Name) ____________ (First Name) ____________ (Middle Initial)

Address ____________ (Street) ____________ (City) ____________ (State) ____________ (Zip)

Email ____________ Sex ❑ M ❑ F Age ______ Birthdate ____________

❑ Married ❑ Widowed ❑ Single ❑ Divorced Children ❑ Yes ❑ No How many? ____________

Occupation ____________ Patient Employer/School ____________

Employer/School Address ____________ Employer/School Phone (_____) ____________

Spouse's Name ____________ Birthdate ____________

Spouse's Employer ____________

Whom may we thank for referring you? ____________

CONTACT INFORMATION

Cell Phone (______) ____________

Phone Provider ____________

Best time and place to reach you: ____________

IN CASE OF EMERGENCY, CONTACT:

Name ____________

Relationship ____________

Home Phone (______) ____________

Work Phone (______) ____________

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No

Date ____________

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?
❑ Auto Insurance ❑ Employer
❑ Workers' Comp. ❑ Other

Attorney Name (if applicable)

____

CHIROPRACTIC HISTORY

Have you been to the chiropractor before? ❑ Yes ❑ No

For what purpose? (Check all that apply)

❑ Pain Relief ❑ Performance

❑ Maintenance ❑ Wellness

PATIENT CONDITION

Reason for Visit? ____________

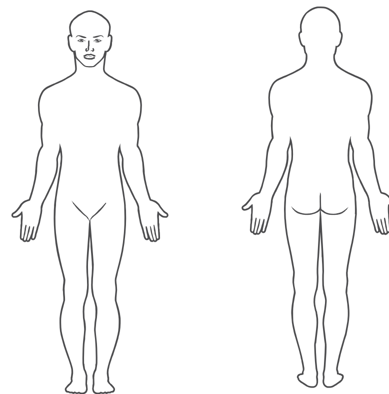
____

When did your symptoms appear? ____________

____

Is this condition getting progressively worse?
❑ Yes ❑ No ❑ Unknown

Mark an **X** on the picture where you continue to have numbness, or tingling.



KEY

P = Pain
N = Numbness
B = Burning
T = Tingling
Th = Throbbing
M = Tightness

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). ____________.

How frequently do you have this pain? ❑ Constant
❑ Frequent ❑ Occasional ❑ Intermittent

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine
❑ Recreation How? ____________

Activities or movements that are painful to perform.
❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down
❑ Squatting ❑ Lifting Overhead ❑ Driving

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HEALTH HISTORY

TREATMENTS

What treatment have you already received for you condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractic Services ❑ None ❑ Other ______________________________ When __________

Name and location of other doctor(s) who have treated you for your condition ______________________

Date of Last: Physical Exam______________ Spinal X-Ray ______________ Blood Test ______________

Spinal Exam ______________ Chest X-Ray______________ MRI, CT-Scan, Bone Scan________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Allergy Shots	❑ Yes	❑ No	Chicken Pox	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Prostate Problem	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Anorexia	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Migraine Headaches	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Miscarriage	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Goiter	❑ Yes	❑ No	Mononucleosis	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Autoimmune Condition	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Bleeding Disorders	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No	Tumors, Growths	❑ Yes	❑ No
Breast Lump	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No	Hernia	❑ Yes	❑ No	Parkinson's Disease	❑ Yes	❑ No	Frequent Illness	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Herniated Disc	❑ Yes	❑ No	Pinched Nerve	❑ Yes	❑ No	Tension Headaches	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Pneumonia	❑ Yes	❑ No	Other ______________		
			High Cholesterol	❑ Yes	❑ No	Polio	❑ Yes	❑ No	______________		

EXERCISE

❑ None
❑ Minimal
❑ Moderate
❑ Daily
❑ Heavy

What type(s)?
❑ Weights
❑ Yoga
❑ Running
❑ Other______________

WORKING ACTIVITY

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor
❑ Driving
❑ Active

HABITS

❑ Smoking — Packs/Day_______
❑ Alcohol — Drinks/Week_____
❑ Coffee, Soda + Energy Drinks — Cups/Day________
❑ High Stress Level — Reason__________

INJURIES/SURGERIES | DESCRIPTION | DATE

Previous Aches and Pains ____

Head Injuries ____

Broken Bones ____

Dislocations ____

Surgeries ____

MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS

______________________ | ______________________ | ______________________

______________________ | ______________________ | ______________________

Pharmacy Name ______________________

Pharmacy Phone (______)______________

Dietary Habits ____

____

Estimated Daily H2O: ____

TREATMENT GOALS

What are your goal(s) with treatment? ____

____