# Charlotte Chiropractic & Sports Injury Clinic

Today's Date: ________/________/________

**Patient Name:** ____________________________________________________________

**Last** **First** **MI**

Your Preferred Name:_______________________________ ☐ Male ☐ Female

Birth date :______/______/______ Age:_____________ SS#_______________________

Mailing Address:_______________________________________________________________

_____________________________________________________________________________

City ST Zip

Home Phone #:__________________________ Cell Phone #:_________________________

Work Phone #:___________________________ Ext:____________

Email Address:____________________________________________

Referred By:______________________________________________

Employer:________________________________________ How Long?__________________

Employer's Address:____________________________________________________________

_____________________________________________________________________________

City ST Zip

Occupation:___________________________________________________________________

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name:________________________________________________________________

Do you have any children? ☐ YES ☐ NO How Many? ___________________

**In event of emergency** whom should we contact?_________________________________

Relation:_______________________________ Home Phone #:________________________

Work Phone #:__________________________ Cell Phone #:_________________________

Medical Doctor:_________________________ Phone #:____________________________

**Person ultimately responsible for account (If other then yourself)**

Name:_________________________________________ Relation:_____________________

Billing Address:_______________________________________________________________

_____________________________________________________________________________

City ST Zip

SS#:___________________________________ D.L. #________________________________

Work Phone #___________________________ Cell Phone #___________________________

**Payment method:** ☐ CASH ☐ CHECK ☐ CREDIT CARD

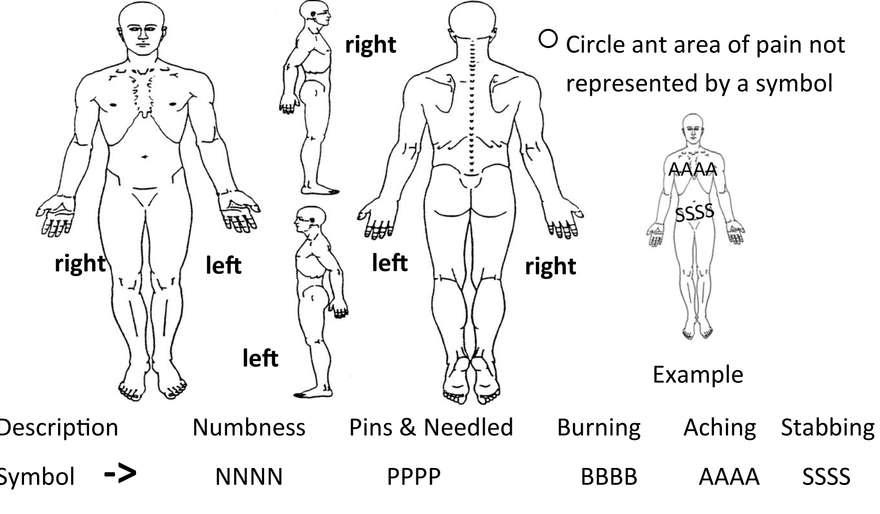
_____________________________________________________________________________

**Enter Card Number Above (If Excepted)**

**TURN OVER**

*SHOW US WHERE IT HURTS*

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)




○ Circle ant area of pain not represented by a symbol

| Description | Numbness | Pins & Needled | Burning | Aching | Stabbing |
|---|---|---|---|---|---|
| Symbol -> | NNNN | PPPP | BBBB | AAAA | SSSS |

The reason for this visit is a result of (circle):
work, sports, auto, trauma or chronic

Explain what happened:________________
____________________________________
____________________________________
____________________________________

Please describe the pain & its location:
____________________________________
____________________________________

When did the condition begin?____/____/____

Is the condition getting worse? (circle)

Yes No Constant Comes and goes

If so please explain:________________________
____________________________________
____________________________________

Have you ever been to a Chiropractor before?

Yes No

If so, by whom?__________________________

Phone #________________________________

## *HEALTH HISTORY*

**Are you taking any of the following medications? (Circle)**

**Nerve Pills Pain Killers (including aspirin) Muscle Relaxer Stimulants Blood Thinners Tranquilizers Insulin**

**Other(s)________________________________**

**Do you have or have you ever had any of the following diseases or conditions?**

| | | |
|---|---|---|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol/Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV+/ AIDS | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Emphysema/Glaucoma | Y N Anemia |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/Frequent Headaches | Y N Kidney Problems | Y N Ulcers/Colitis |
| Y N Fainting/Seizers/Epilepsy | Y N Sinus Problems | Y N Asthma |
| Y N Diabetes/Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Problems | Y N Artificial Bones/Joints | Y N Arthritis |

Please list any other serious medical condition(s) you have or have ever had:________________________________________
____________________________________________________________________

Please list anything that you may be allergic to:____________________________________________________
____________________________________________________________________

List previous surgeries/treatments with dates:______________________________________________________
____________________________________________________________________

List any **past** serious accidents with dates:______________________________________________________
____________________________________________________________________

Family Health History**:**______________________________________________________________

Do you: Take supplements or vitamins? YES NO Exercise? YES NO

Are you on a special diet? YES NO Since: _____/_____/_____

Do you smoke? YES NO How Much?____________________ How Long?:_________________________

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

How old is your mattress?_________________ Is it comfortable? YES NO

**For Women:** Are you taking birth control YES NO

Are you pregnant? YES NO How far along?_______________ Nursing? YES NO