



Pn: \_\_\_\_\_

**GENERAL INFORMATION:**

Name: \_\_\_\_\_  Male  Female SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status (circle one): S M W D #Children: \_\_\_\_\_

Local Address: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone#: \_\_\_\_\_ Work: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cellular: \_\_\_\_\_ Email: \_\_\_\_\_

Check if Permanent Address is the same as Local Address Your occupation: \_\_\_\_\_

Permanent Address: \_\_\_\_\_ Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Are you a student?  Full Time  Part Time

Permanent Phone #: \_\_\_\_\_  I am not a student

**CURRENT COMPLAINTS:**

When did your present conditions start? \_\_\_\_\_ Is this the first occurrence?  Yes  No

What aggravates these conditions: \_\_\_\_\_

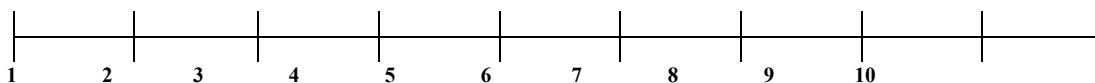
What decreases the symptoms or pain? \_\_\_\_\_

**SYMPTOMS:**

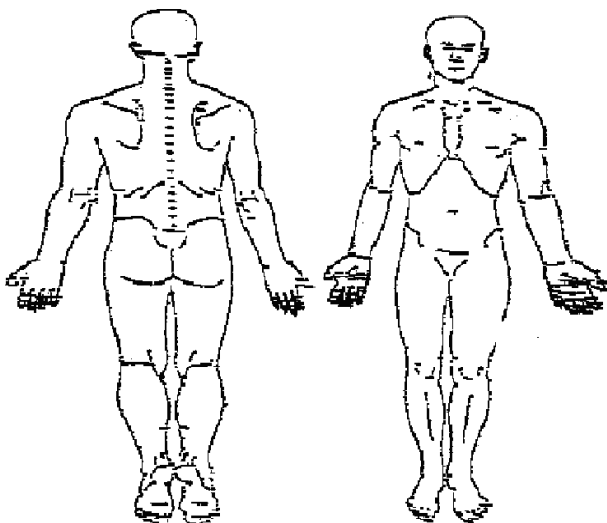
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Elbow Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Mid Back Pain
<input type="checkbox"/> Wrist Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Ankle Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Hand Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Foot Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> _____
<input type="checkbox"/> Thigh Pain	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Headaches		<input type="checkbox"/> _____

**PAIN INDEX:**

On a scale of 1 to 10, how strong is the pain now? (1 being no pain and 10 being severe pain)



Using the symbols provided below, mark the areas on the illustrations where you are experiencing these sensations.



BURNING	XXXXXXXXXXXX
STABBING	//////////
PINS & NEEDLES	*****
ACHING	0000000000
NUMBNESS	-----



**DAILY ACTIVITIES (please rate) :**

Please rate the following from 1 to 10; where 1 indicates no difficulty performing the activity and 10 indicates severe pain/no ability.

Sitting	Bending forward	Pulling	Lying on Back
Standing for over 1hr	Bending backward	Dressing self	Lying on side with knees bent
Reaching	Climbing stairs	Stooping	Coughing
Getting in/out of the car	Turning over in bed	Pushing	Personal grooming
Lifting	Sleeping	Kneeling	Walking
Sneezing	Carrying small items	Jogging	Other _____

**PAST MEDICAL HISTORY:**

Gastrointestinal		Cardio/Respiratory	Integumentary
<input type="checkbox"/> Black/tarry stools	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Dry skin
<input type="checkbox"/> Constipation	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Blood Pressure problems	<input type="checkbox"/> Itching
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Poor/excessive appetite	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Rashes
<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Unusual masses
<input type="checkbox"/> Frequent nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Shortness of breath	<b>Genitourinary</b>
<input type="checkbox"/> Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/> Lung problems/congestion	<input type="checkbox"/> Breast pain
<b>Ears, Nose, Throat, Eyes</b>		<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Difficult urination
<b>Nervous System</b>		<b>Women Only</b>	
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Cold/tingling extremities	<input type="checkbox"/> Menstrual cramping/pain	<input type="checkbox"/> Genital pain
<input type="checkbox"/> Earaches	<input type="checkbox"/> Confusion/depression	<input type="checkbox"/> Vaginal pain	<input type="checkbox"/> Genital herpes
<input type="checkbox"/> Hearing difficulties	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Irregular period	<input type="checkbox"/> Urine discoloration
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Fainting	<input type="checkbox"/> Currently pregnant	<b>Men Only</b>
<input type="checkbox"/> Taste/smell problems	<input type="checkbox"/> Forgetfulness		<input type="checkbox"/> Prostate/sexual dysfunction
<input type="checkbox"/> Vision difficulties	<input type="checkbox"/> Paralysis		

**SOCIAL HISTORY:**

**MEDICATIONS/ALLERGIES:**

Alcohol	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	Do you have any drug allergies? <input type="checkbox"/> Y <input type="checkbox"/> N
Drug Use	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	
Tobacco Use	<input type="checkbox"/> Never	Packs/Day			If yes, please list:
Coffee	<input type="checkbox"/> Never	Cups/Day			
Exercise	<input type="checkbox"/> Never	<input type="checkbox"/> 1x Week	<input type="checkbox"/> 2x Week	<input type="checkbox"/> 3x Week	List current medications and their use:
What kind of exercise?					

**PAST MEDICAL HISTORY:**

Review the listed conditions. Check the appropriate box if you have ever had that particular condition. Although these problems may be unrelated to your current condition, these problems may either affect your diagnosis, your treatment plan or even whether or not you are accepted for care.

General	Medical Conditions		Family History		
			Mother	Father	Sibling
<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fever	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Back Problems	<input type="checkbox"/>	<input type="checkbox"/>



**AUTHORIZATIONS:**

Please read the following statements carefully and check each one after reading:

- 1. Authorization to Release Medical Information**  
 I hereby authorize the release of medical information pertinent to my case to the insurance company or to the attorney involved in my case. I further authorize the release of my medical records and reports to Commonwealth Chiropractic.
- 2. Privacy Notice Acknowledgment**  
 With my signature below, I acknowledge that I have received a copy of the Commonwealth Chiropractic Notice of Privacy Practices, or viewed the Notice online at www.commchiro.com.
- 3. Informed Consent**  
 I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, and have been informed of the risks and possible consequences involved with this treatment, as detailed in the Commonwealth Chiropractic Informed Consent Notice, available at the Front Desk or viewed online at www.commchiro.com.
- 4. Financial Responsibility**  
 I understand that I am fully responsible to Commonwealth Chiropractic for all charges I incur in this office, including deductibles, co-pays, co-insurance and all charges not covered by my insurance, as detailed in Commonwealth Chiropractic's Financial Policy available at the Front Desk or viewed online at www.commchiro.com.

**I agree to the authorizations listed above and I certify that all the information is complete and true to the best of my knowledge.**

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name (please print): \_\_\_\_\_

**ACCOUNT INFORMATION:**

All accounts not paid by insurance will be charged to my credit card:

Visa     MC     AmEx     Discover    Card #: \_\_\_\_\_ Exp. Date \_\_\_\_\_

I authorize Commonwealth Chiropractic to bill my balance to my credit card monthly.

**WELCOME!**

**It is our pleasure to have you as a new patient! Please help us thank the person or organization who referred you!**

How were you referred to our office? \_\_\_\_\_

**Thank you very much and welcome to Commonwealth Chiropractic!**