TYSDAL CHIROPRACTIC

Please fill out this form in detail. The information will be used to assist the doctor in best serving you.
The information is confidential and will only be used for clinical purposes.

Patient Information

Today's Date:_____

Full Name:_____ Preferred Name:_____ Sex: ◯ Female ◯ Male

Address: _____ Apt./Unit Number_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Work #:_____ Cell #:_____

Email:_____ Birth Date:_____ (Age:_____) SS#: _____

Occupation:_____ Employer:_____

Marital Status: □ Single □ Married □ Other Name of Spouse:_____

Names/Ages of Children At Home:_____

Name and Number of Emergency Contact:_____

How were you referred to Tysdal Chiropractic?

□ Family Member □ Friend □ Doctor □ Internet □ Newspaper □ Phone Book □ Other_____

Please give us the name of the family member, friend or doctor that referred you:_____

Insurance Information

Insurance Company:_____ Policy Number: _____Group Number:_____
Policy Holder's Name:_____ Policy Holder's Birth Date:_____
Policy Holder's Relationship to the Patient: □ Self □ Spouse □ Parent/Guardian □ Other_____

Chiropractic History

Have you been under Chiropractic care before? □ Yes □ No If yes, date of last visit?_____

Was your chiropractic experience positive, negative, neutral?_____

Reason:_____

Current and Past Conditions

*Please indicate if you have or have had any of these conditions

□ Headaches	□ Back Pain	□ Neck Pain	□ Pins/ Needles in Arms/Legs
□ Shoulder Pain	□ Stress	□ Muscle Tension	□ Overall Joint Pain/Stiffness
□ Difficulty Walking/Sitting	□ Difficulty Driving	□ Difficulty Working	□ Difficulty Lifting/Bending
□ Weakness	□ Loss of Balance/Dizziness	□ Fatigue	□ Loss of Coordination
□ Frequent Colds/Flu	□ Ringing in Ears	□ Sinus Problems	□ Diarrhea/Constipation
□ Indigestion	□ Sleeping Problems	□ Allergies	□ Asthma
□ Anxiety	□ Depression	□ Moody/ Irritable	□ Lack of Concentration
□ High Blood Pressure	□ Vision Problems	□ Poor Memory	□ Menopausal Difficulties
□ Fertility Dysfunction	□ Prostate Dysfunction	□ Sexual Dysfunction	□ Menstrual Difficulties

Surgeries:_____

Serious illness or injury:_____

Allergies:_____

Habits: Smoking/Tobacco use? □ Yes □ No Alcohol use? □ Yes □ No If yes, how many drinks per week? _____

Medications taken within the last two months (include over the counter and vitamins):_____

_____

Occupational Stresses:_____

Are there any other issues concerning your health that you would like the doctor to be aware of?_____

Have you had any other significant traumas? (Auto accidents, falls, etc…): □ Yes □ No

If Yes, Please Describe: _____

_____

The MAJOR Symptom/Complaint

Major Complaint:_____

Have you had this problem before? □ Yes □ No When did the problem start?_____

How did this problem start? _____

Is the problem related to an auto/work accident? □ Yes □ No

If yes, what is the date of the accident? _____

Please describe your current pain:

□ Sharp □ Dull Ache □ Numb □ Shooting □ Burning □ Tingling

□ Other _____

Since your problem began, is the pain...

□ Increasing □ Decreasing □ Not Changing

How frequently does your pain occur?

□ Constantly □ Frequently □ Occasionally □ Intermittently

What makes your problem better? _____

_____

What makes your problem worse? _____

_____

Please list other health care providers consulted for this condition:

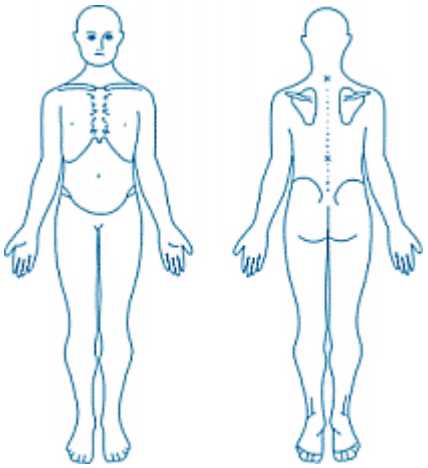
_____

Date of last physical examination: _____

Women: Are you/ is there a possibility that you may be pregnant? □ Yes □ No

If yes, what is the due date? _____

Please mark the location(s) where you have pain or other symptoms.



*Please rate the severity of your pain

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

THE STATEMENTS MADE ON THESE FORMS ARE ACCURATE TO THE BEST OF MY RECOLLECTION AND I AGREE TO ALLOW THIS OFFICE TO EXAMINE ME FOR EVALUATION.

Signature: _____Date: _____

If under 18, Parent/Guardian Signature: _____Date: _____