OAK ROAD FAMILY CHIROPRACTIC

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Lilburn, GA 30047
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Confidential Patient History

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to best understand your health problems, please complete this form neatly, accurately, and completely. **Thank You.**

Personal Information

Patient Name: _____Today's Date: _____

Address: _____ SS#_____-_____-_____

_____ Birth date_____

(City) (State) (Zip Code) Age_____

Home Phone # :(_____) _____Cell Phone or Pager #_(_____) _____

Marital Status **S M D W** # of Children _____Ages_____

Email Address_____

Employer Information

Occupation_____Employer_____

Address_____

Work Phone #_(_____) _____

Spouse's Information

Spouse's Name_____

Occupation_____Employer_____

Work Phone #_____Nearest Relative & phone#_____

Reason for your visit today

List present complaints, injuries and the duration of your problem

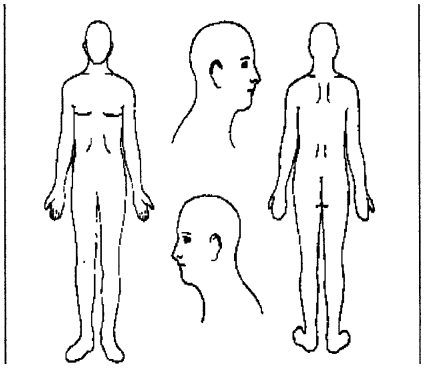
1. **(Date of Onset)**_____

_____

2. **(Date of Onset)**_____

_____

3. **(Date of Onset)**_____



_____**Please mark areas of problem on the figures above**

Please rate (Circle) the pain on a scale of 1-10 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Describe the pain or condition:

____sharp ____dull ____intermittent ____localized ____aching

____stabbing ____constant ____radiating ____burning ____throbbing

____numbness ____tingling ____shock-like ____other_____

Any other details that might help the doctor? _____

_____

Have you ever been to a Chiropractor before? **YES** or NO

How did you hear about this office? _____

Have you had any surgery, accidents (broken bones), major illnesses, or injuries? If so, please give dates and describe

_____

_____

Is it possible that you are **pregnant**? **YES** or NO

Do you have health insurance? **YES** or NO **(If Yes, Please give insurance card to front desk)**

Are you on Medicare? **YES** or NO **(If Yes, Please give Medicare card to front desk)**

Have you seen another professional for this condition? **YES** or **NO**

If so, then who? _____

Are you currently under a physician's care for this or any other reason? **YES** or **NO**

If yes, please explain? _____

Are you currently taking any medications or nutritional supplements? **YES** or **NO**

If so, please list _____

Habits

____Smoking pack/s/day____ ____Alcohol drinks/week____

____Coffee/Caffeine cups/day____ ____High Stress Level Reason_____

Exercise: Light Moderate Heavy Daily Weekly Sporadically None at all

Work Activity: ____Sitting ____Standing ____Light Labor ____Heavy Labor ___At Computer

Sleep Habits: ____On stomach ____On back ____On side **Quality:** ____Good ____Poor

Health Makes You Smile!