QUAD CITY Spine Clinic

Date _____ File # _____

PATIENT INFORMATION

Patient Name _____
First M Last

What do you preferred to be called? _____

Date of Birth _____ Gender ☐ Male ☐ Female ☐ Transgender

Patient SSN# _____ Do you? ☐ Rent ☐ Own

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email _____

Occupation _____

Employer/ School _____

Employer/ School Address _____

City _____ State _____ Zip _____

Employer/ School Phone _____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Minor

☐ Partnered for ____ years ☐ Other _____

Spouse's Name _____

Spouse's SSN# _____ Date of Birth _____

Spouse's Cell Phone _____

Spouse's Employer _____

Do you have children? ☐ Yes ☐ No How many? _____

How did you hear about us? _____

PATIENT CONDITION

What is your main complaint? _____

How long have you had this problem? _____

What started the problem? _____

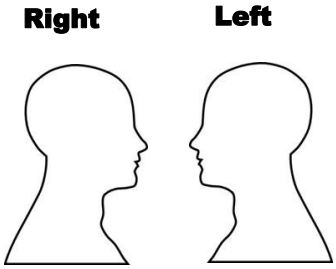
_____

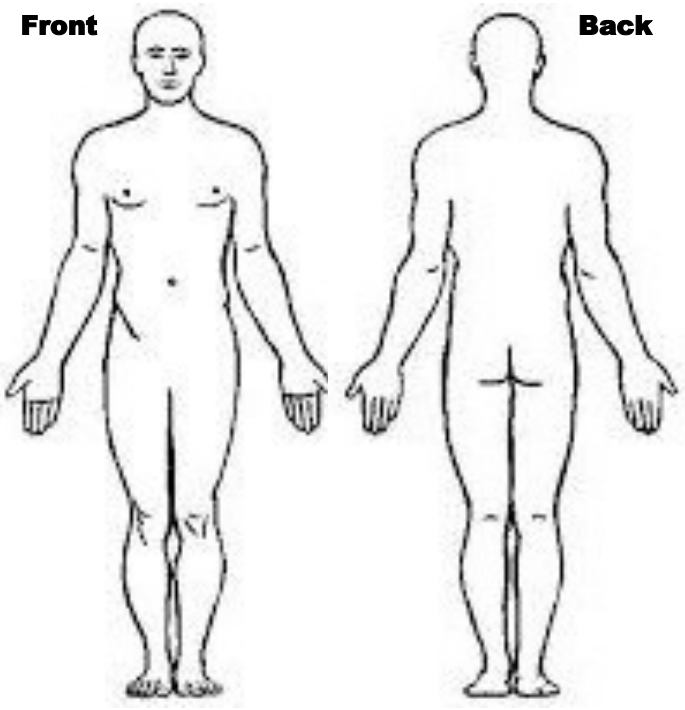
RATE YOU PAIN

Place an "X" on the drawings below wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache	N=Numbness
B=Burning	P=Pins and Needles
ST=Stabbing	T=Throbbing
SP=Spasm	

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)





PAIN SCALE: (Please circle the number that best describes your overall pain)

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

Patient Name:_____**Date:**_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe: _____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Please list any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):

_____

_____

_____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe:_____

What medications or drugs are you taking? _____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you ever been under Chiropractic Care? ___Yes___No

If so, when was your last visit? _____Reason?_____

Dr.'s Name_____Phone Number_____

Patient Name _____ **Quad City Spine Clinic**

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now **P = Previously**

Headaches_____ Frequency _____
Neck Pain _____
Stiff Neck _____
Sleeping Problems _____
Back Pain _____
Nervousness _____
Tension _____
Irritability _____
Chest Pains/Tightness _____
Dizziness _____
Shoulder/Neck/Arm Pain _____
Numbness in Fingers _____
Numbness in Toes _____
High Blood Pressure _____
Difficulty Urinating _____
Weakness in Extremities _____
Breathing Problems _____
Fatigue _____
Lights Bother Eyes _____
Ears Ring _____
Broken Bones/Fractures _____
Rheumatoid Arthritis _____
Excessive Bleeding _____
Osteoarthritis _____
Pacemaker _____
Stroke _____
Ruptures _____
Eating Disorder _____
Drug Addiction _____
Gall Bladder Problems _____
Ulcers _____

Loss of Balance _____
Fainting _____
Loss of Smell _____
Loss of Taste _____
Unusual Bowel Patterns _____
Feet Cold _____
Hands Cold _____
Arthritis _____
Muscle Spasms _____
Frequent Colds _____
Fever _____
Sinus Problems _____
Diabetes _____
Indigestion Problems _____
Joint Pain/Swelling _____
Menstrual Difficulties _____
Weight Loss/Gain _____
Depression _____
Loss of Memory _____
Buzzing in Ears _____
Circulation Problems _____
Seizures/Epilepsy _____
Low Blood Pressure _____
Osteoporosis _____
Heart Disease _____
Cancer _____
Coughing Blood _____
Alcoholism _____
HIV Positive _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise
_____ Moderate Exercise
_____ Alcohol Use
_____ Drug Use
_____ Tobacco Use
_____ Caffeine
_____ High Stress Activity

_____ Family Pressures
_____ Financial Pressures
_____ Other Mental Stresses
_____ Other (specify)_____
_____
_____

Patient Name _____ **Quad City Spine Clinic**

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

_____

Additional information you would like to discuss with Doctor?

_____

_____

_____

_____

_____