Welcome To Paul Family Chiropractic

CONFIDENTIAL PATIENT INFORMATION

Name: ________________________ Sex: Male / Female Date Of Birth: ___/___/___ Age:_____

Address:________________________ City: ________________ State:_______ Zip:________

Phone: (home)________________(work)__________________ S.S.#________________

Occupation:________________ Employer: ________________Employer Phone:____________

Employer Address:________________City:________________ State:________ Zip:_______

In case of Emergency Contact:________________________Phone:____________________

Marital Status: S M D W Name of Spouse:________________ Children, Number of: 1 2 3 4 5_____

Who may we thank for referring you to our office? Family / friend (name)____________________

Have you ever been to a Chiropractor Before? ☐ Yes ☐ No, If Yes, when? ____________________

Reason for today's Visit? ☐ **Symptom free Spinal Evaluation** ☐ **Symptomatic Evaluation**

Health Concern (list 2 in order of severity) **Mark an " x " on the picture where you have Pain, Numbness, Tingling**

1.________________Is Condition getting worse? ☐ Yes ☐ No,

When did it first appear?____________, Is it ☐ Constant ☐ Comes & Goes

Rate severity of problem on a scale of 1(least pain) to 10 (worst pain)_________

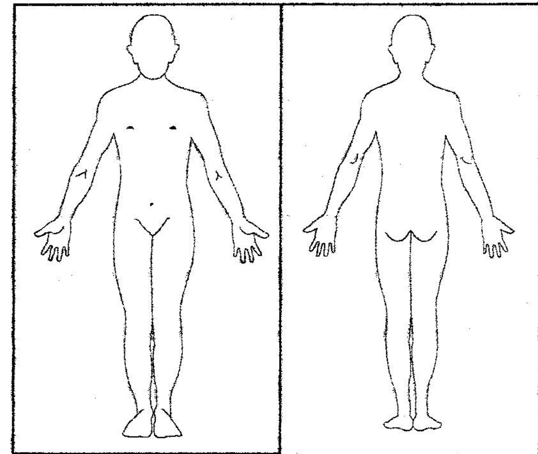
Type of pain: ☐ Sharp ☐ Dull ☐ Numbing ☐ Tingling ☐ Shooting

2.________________Is Condition getting worse? ☐ Yes ☐ No,

When did it first appear?____________, Is it ☐ Constant ☐ Comes & Goes

Rate severity of problem on a scale of 1(least pain) to 10 (worst pain)_________

Type of pain: ☐ Sharp ☐ Dull ☐ Numbing ☐ Tingling ☐ Shooting



Have you consulted / received treatment for theses conditions? ☐ Yes ☐ No, When, If yes, and by whom,____________

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TRAUMA (AUTO ACCIDENTS/ FALLS/ WORK INJURIES/BROKEN BONES)

Broken bones Yes / No When?________________ Received Treatment? Yes / No

Auto Accidents Yes / No When?________________ Received Treatment? Yes / No

Slips & Falls Yes / No When?________________ Received Treatment? Yes / No

Work Injury Yes / No When?________________ Received Treatment? Yes / No