Cary Chiropractic

WELCOME to Cary Chiropractic

Patient Information **Date**

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth_____/_____/_____ **Sex:** Male Female

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer Name _____

Occupation _____ **Job Description** _____

Spouse's Name _____ **Occupation**_____

Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Emergency Contact Name _____ **Relationship**_____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

How did you hear about our office? _____

Primary Care Physician Name_____ **Office Phone #**_____

Previous Chiropractor (s)_____

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Medical Conditions: (Mark all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke

Other _____

Surgeries: (Mark all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia

Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never

Other _____

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Please list all current medications/supplements being taken

_____

_____

Are you pregnant? Yes_____ No _____

Are you here as a result of: Motor Vehicle Accident Work Accident Other_____

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Review of Systems– (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

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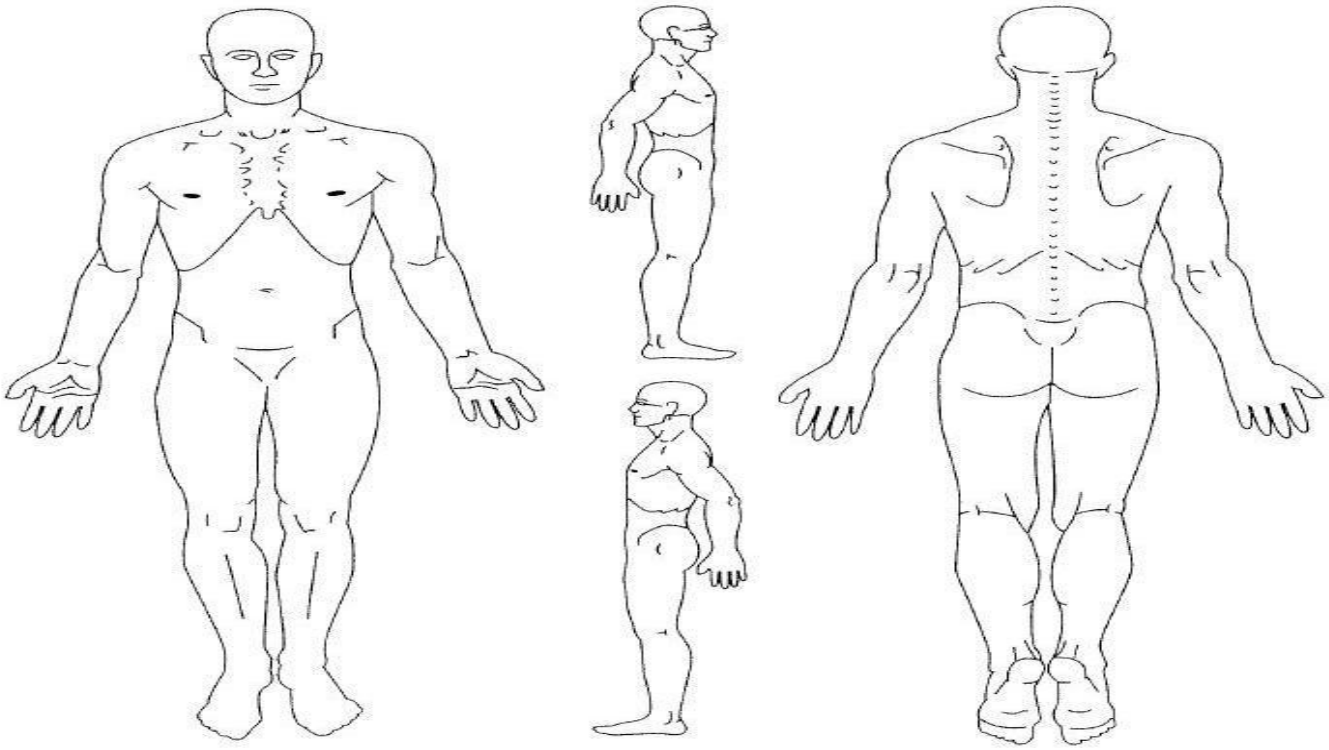
By Using the key below, indicate on the body diagram where you are experiencing the following:
N=Numbness B=Burning S=Stabbing/Sharp T=Tingling A=Dull Ache



When did your symptoms begin:_____

Describe your symptoms and how they began: _____

_____

_____

Have you seen anyone else for this: _____

What did they do for it: _____

Have you experienced this before? If so, when:_____

How often throughout the day do you experience your symptoms? Constantly (75-100%) Frequently (50-75%) Occasionally (25-50%) (0-25%) Intermittently

How are your symptoms changing? Getting better Not changing Getting worse

What makes it better:

What makes it worse:

What is your current pain level: 0 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect daily living: None Mildly Moderately Severely