# 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) ____________________________________

Cary Chiropractic

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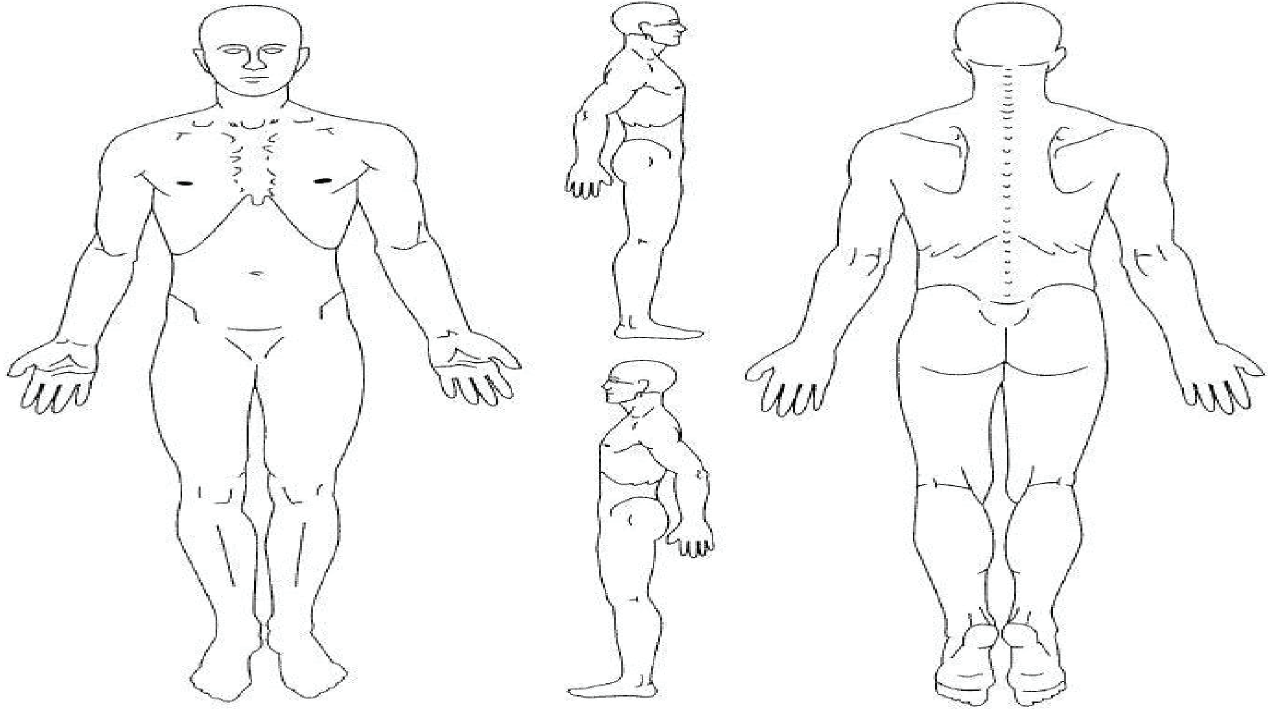
**Review of Systems** – *(Check box if you have had trouble with any of the following, circle NO if none)*

| 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 | | | | | | | | | | | |
| | | | | | | | | | | | |

**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%) ☐ Intermittently (0-25%)

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