PATIENT INTRODUCTION

Date_____ Case #_____

Name_____ Nickname_____
Address_____ City_____ State_____ Zip_____
Land Line_____ Cell Phone_____ Work Phone_____
Sex: M F Marital Status: S M D W Birth date_____/_____/_____ Soc. Sec. #_____
How did you hear about our clinic? _____ Employer_____
***Would you like to receive text or email appointment reminders? ☐ Yes TEXT ☐ Yes EMAIL ☐ No**
***Cell Phone Number: _____ *AND* *Cell Phone Carrier *(Required)*:_____**
E-mail address _____Would you like to receive a quarterly newsletter? Yes / No
How far in advance would you like to receive reminders? *(Select One)*? ☐1 week ☐1 day ☐4 hours ☐1 hour

PRESENT COMPLAINT

Briefly describe Symptoms:_____

Other doctors seen for this condition:_____ Treatment rendered:_____

List any and all medications that you are **currently taking** or have taken **in the last 3 months**:

Medication	*Last Taken*	*Medication*	*Last Taken*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Physicians seen within the last year:	*For what conditions:*
_____	_____
_____	_____
_____	_____

List all surgeries:	*When?*	*Surgery:*	*When?*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you pregnant? Yes / No Date of last Menstrual Period:_____

INSURANCE INFORMATION

Insured's Full Name_____ Soc. Sec. #_____
Address (If different from pt.) _____ City_____
State_____ Zip_____ Home Phone_____
Relationship to insured: Self Spouse Child Other_____
Insurance Company_____ Phone #_____
Group #_____ Insured ID #_____ Insured DOB_____
Employed by:_____

Additional Insurance (2nd Policy)
Insured's Full Name_____ Soc. Sec. #_____
Relationship to insured: Self Spouse Child Other_____
Insurance Company_____ Phone #_____
Employed by:_____ Insured DOB_____

FEES PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE

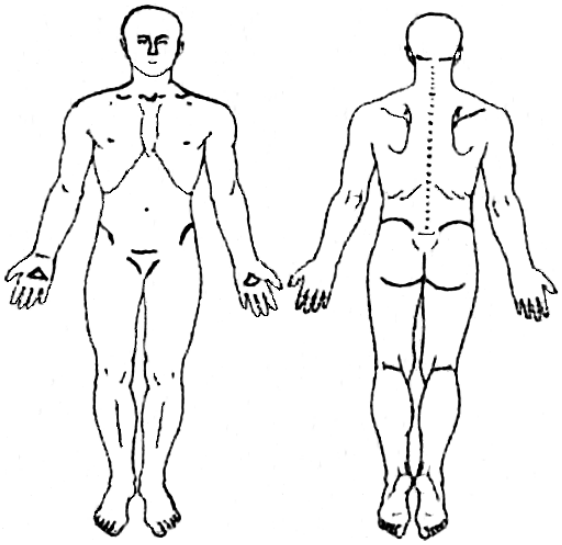
Cromwell Family Chiropractic

CONSULTATION

DATE:_____

CASE # _____

Mark the areas on your body where you feel the Described sensations. Use the appropriate symbol to mark all affected areas.



NUMBNESS	BURNING	STABBING	PINS & NEEDLES
" " "	x x x	/ / /	0 0 0

NAME_____

MAJOR COMPLAINTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did this condition develop? _____

_____

Any accidents, falls, etc. that might have caused your problem? _____

When was the very first time you experienced these symptoms? _____

Have you previously experienced this type of condition? _____

Have you received any treatment for this condition? _____

Has this problem been getting better, worse, or staying the same? _____

Is there anything you do that makes your condition worse? _____

How has this condition affected your:

A. Home life _____
B. Occupational life _____
C. Recreational activities _____
D. Rest and Sleep _____

Have you ever been in an automobile accident? Past year: _____ Past 5 years: _____Over 5 years:_____Never:_____

Have you ever seen another doctor for this problem? _____

Are you currently taking any medication? (also: aspirin, birth control pills, etc.) _____

Any chiropractic consulted in the past? Name: _____

Date consulted: _____ For what problem: _____

CURRENT OR PREVIOUS SYMPTOMS

Indicate current symptoms with "C" and previous symptoms with "P"

	HEADACHE		NUMBNESS IN FINGERS, ARMS, LEGS		DIGESTIVE DISORDERS		EXTREME FATIGUE
	HEAD SEEMS TOO HEAVY		CHEST PAIN		NAUSEA, VOMITING		SHORTNESS OF BREATH
	LOSS OF MEMORY		EYE STRAIN		DIARRHEA		PAIN RADIATING INTO
	EQUILIBRIUM PROBLEMS		PAIN BEHIND EYES		CONSTIPATION		* ARM Right / Left
	DIZZINESS		EYES SENSITIVE TO LIGHT		DIFFICULTY IN EXCESSIVE LIFTING		* BOTH
	FAINTING		EARS BUZZING / RINGING		* LIGHT / MODERATE		* LEG Right / Left
	TREMORS / PALPITATION		LOSS OF TASTE / SMELL		* HEAVY		* BOTH
	NECK PAIN / STIFFNESS		SINUS TROUBLE		* REPETITIVE		* NECK
	NECK MOTION RESTRICTED		EXTREME NERVOUSNESS		DIFFICULTY IN EXCESSIVE		* BASE OF SKULL
	UPPER BACK PAIN / STIFFNESS		TENSION / IRITABILITY		* STANDING		* SHOULDER
	MID BACK PAIN / STIFFNESS		ANXIETY / DEPRESSION		* WALKING		* HIPS
	LOW BACK PAIN / STIFFNESS		INSOMNIA		* RIDING		
	PINS & NEEDLES IN ARMS / LEGS		EXCESS PERSPIRATION		* BENDING		