HANDS ON
CHIROPRACTIC & WELLNESS CLINIC

INITIAL PATIENT DATA
(PLEASE FILL IN ALL BLANKS)

IS THIS VISIT DUE TO AN ACCIDENT? ☐ YES ☐ NO

NAME ______________________ DATE __________

STREET ADDRESS ______________________

CITY ______________ STATE ________ ZIP __________

SSN ____________ DOB ________ AGE ______ GENDER M F

HOME PHONE # __________ WORK # __________ CELL # __________

OCCUPATION ______________ EMPLOYER ______________

DRIVER'S LICENSE # ______________ STATUS M S W D

SPOUSE'S NAME ______________________

IN CASE OF EMERGENCY, I REQUEST THAT YOU CONTACT:

NAME ______________ PHONE ______________

ADDRESS ______________________

PAST MEDICAL HISTORY
(PLEASE CHECK ALL THAT APPLY)

- **CANCER** Type__________
- **TUBERCULOSIS**
- **HEART PROBLEMS**
- **SINUS**
- **SKIN LESIONS**
- **DIABETES** ☐ Type I ☐ Type II
- **HEPATITIS**
- **ASTHMA**
- **CONCUSSION**
- **ACQUIRED IMMUNE DEFICIANCY SYNDROME**
- **HIGH BLOOD PRESSURE**
- **DIGESTIVE PROBLEMS**
- **ANEMIA**
- **EPILEPSY**
- **STROKE**
- **VENEREAL DISEASE**
- **PROSTATE PROBLEMS**
- **ARTHRITIS** Type __________

DESCRIBE AND DATE ANY SURGICAL PROCEDURES______________

HAVE YOU RECEIVED TREATMENTS BY ANY PHYSICIAN THIS YEAR? ☐ YES ☐ NO

DESCRIBE REASON ______________________

DATE OF LAST EXAM ______________ ARE YOU PREGNANT? ☐ YES ☐ NO

ARE YOU TAKING ANY MEDICATIONS? ☐ YES ☐ NO WHAT TYPE? __________

____

SIGNATURE ______________________ DATE __________

(IF THIS VISIT IS DUE TO AN ACCIDENT, PLEASE FILL IN ACCIDENT REPORT ON REVERSE SIDE)

ACCIDENTAL INJURY REPORT

Date of Accident ______________________ Time of Accident __________ AM __________ PM

Type of Accident: ☐ Motor Vehicle ☐ Work ☐ Slip/Fall ☐ Other ____________________

MOTOR VEHICLE

Type of Vehicle You Were In: ☐ Car ☐ Truck ☐ Motorcycle

You were: ☐ The Driver ☐ Passenger ☐ Pedestrian

If passenger, please mark "X" for your position in the car:

Were you injured in this accident? ☐ Yes ☐ No

Were you transported to the hospital? ☐ Yes ☐ No

Name of the hospital/facility where you were treated ______________________________

Were other people inside your vehicle injured? ☐ Yes ☐ No

Was the vehicle you were in damaged? ☐ Yes ☐ No Area of vehicle damaged ______________

Estimated cost of repair ______________________________
(If unknown, leave blank)

Was the accident reported to the Police Department? ☐ Yes ☐ No

Do you have a copy of the police report? ☐ Yes ☐ No

Were traffic citations issued? ☐ Yes ☐ No Who received the traffic citation(s)? ☐ You ☐ Other Driver

Were government vehicles, taxicabs, or buses involved? ☐ Yes ☐ No

Briefly describe the accident ______________________________

____

____

WORK-RELATED ACCIDENT

Employer ______________________________

Address ______________________________

Describe the accident ______________________________

Type(s) of machinery involved ______________________________

Name of person the accident was reported to ______________________________

Have you seen a company doctor? ☐ Yes ☐ No

Are you currently receiving therapy or taking prescribed medications? ☐ Yes ☐ No

Names of medications ______________________________

Has a worker's compensation file been opened? ☐ Yes ☐ No

OTHER ACCIDENT(S) ______________________________

PAIN DRAWING

TELL US WHERE YOU HURT

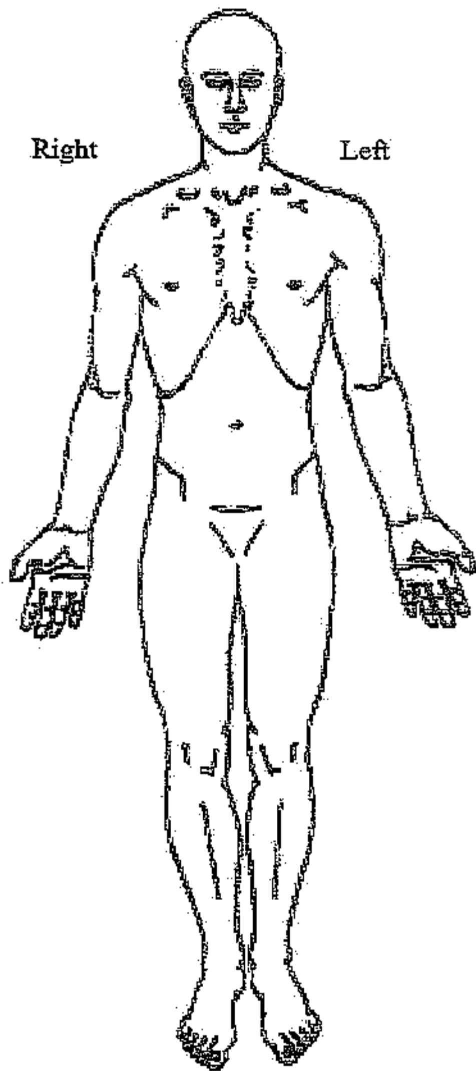
Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

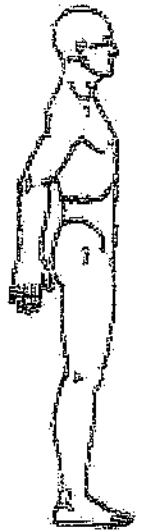
Ache >>>>> Numbness ═══ Pins and Needles oooo

Burning X X X X Sharp/Stabbing / / / / / Throbbing ~~~~~~

FRONT



RIGHT



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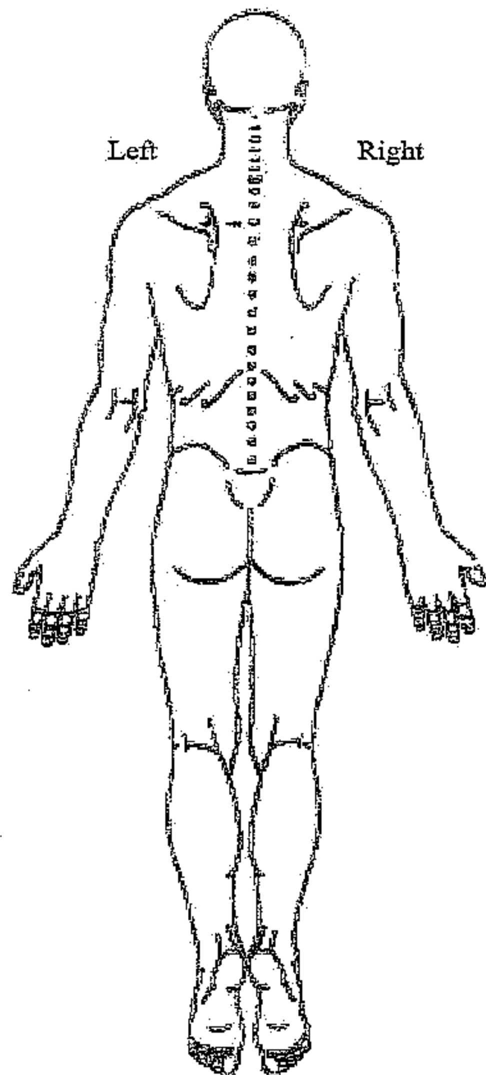
BACK



Name: ______________________________ Date: ____________________

Patient's Name: ______________________________ Date: ______________________

PAIN DESCRIPTION

Please rate your pain on a scale of (1) to (10), 1 indicating mild pain and 10 indicating severe pain.

Headaches	1 2 3 4 5 6 7 8 9 10	Low Back Pain	1 2 3 4 5 6 7 8 9 10
Neck Pain	1 2 3 4 5 6 7 8 9 10	Lt. Hip Pain	1 2 3 4 5 6 7 8 9 10
Lt. Arm/Shoulder/Elbow Pain	1 2 3 4 5 6 7 8 9 10	Rt. Hip Pain	1 2 3 4 5 6 7 8 9 10
Rt. Arm/Shoulder/Elbow Pain	1 2 3 4 5 6 7 8 9 10	Lt. Leg/Knee Pain	1 2 3 4 5 6 7 8 9 10
Lt. Wrist/Hand/Finger Pain	1 2 3 4 5 6 7 8 9 10	Rt. Leg/Knee Pain	1 2 3 4 5 6 7 8 9 10
Rt. Wrist/Hand/Finger Pain	1 2 3 4 5 6 7 8 9 10	Lt. Foot/Ankle/Toe Pain	1 2 3 4 5 6 7 8 9 10
Upper Back Pain	1 2 3 4 5 6 7 8 9 10	Rt. Foot/Ankle/Toe Pain	1 2 3 4 5 6 7 8 9 10
Midback Pain	1 2 3 4 5 6 7 8 9 10	Chest Pain	1 2 3 4 5 6 7 8 9 10
Stomach Pain	1 2 3 4 5 6 7 8 9 10	Shortness of Breath	1 2 3 4 5 6 7 8 9 10
Constipation	1 2 3 4 5 6 7 8 9 10	Dizziness	1 2 3 4 5 6 7 8 9 10
Diarrhea	1 2 3 4 5 6 7 8 9 10	Nervousness/Anxiety	1 2 3 4 5 6 7 8 9 10
Blurred Vision	1 2 3 4 5 6 7 8 9 10	Memory Loss	1 2 3 4 5 6 7 8 9 10
Ear Ringing	1 2 3 4 5 6 7 8 9 10	Depression/Sleep Disturbance	1 2 3 4 5 6 7 8 9 10

How condition occurred ____

Date of Onset __________ Sudden _______ Gradual _______ Accident _______ Auto _______ Work _______

Frequency of complaint 10 20 30 40 50 60 70 80 90 100% of the time

Does pain radiate down arms or legs _____Yes _____No

Type of Pain Ache____ Burning_____ Stabbing_______ Sharp_______ Dull_______ Deep_______ Stiffness_____

Pain irritated by ____

Pain relieved by ____

Previous care for the condition ____

Results of previous care ____

Any prescription meds ____

Prior chiropractic care ____

Do you feel your pain(s) is/are getting better or worse? ____

Are you most uncomfortable in the morning or evening? ____

Have you been able to work since pain began? _____Yes _____No

Complicating factors, previous family history, history of same or similar complaints: ______________________

____

Comments: ____

____

Patient's Signature ______________________________ Date ______________

Review of Systems

Patient Name: ____________________ Patient File #: __________ Today's Date: _____/_____/_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- ☐None
- ☐Chills
- ☐Daytime Drowsiness
- ☐Fatigue
- ☐Fever
- ☐Night Sweats
- ☐Weight Gain
- ☐Weight Loss

Eyes/Vision:
- ☐None
- ☐Blindness
- ☐Blurred Vision
- ☐Cataracts
- ☐Change in Vision
- ☐Double Vision
- ☐Eye Pain
- ☐Field Cuts
- ☐Glaucoma
- ☐Itching *(around the eyes)*
- ☐Photophobia
- ☐Tearing
- ☐Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐None
- ☐Bleeding
- ☐Dental Implants
- ☐Dentures
- ☐Difficulty Swallowing
- ☐Discharge
- ☐Dizziness
- ☐Ear Drainage
- ☐Ear Infection*(s)*
- ☐Ear Pain
- ☐Fainting
- ☐Headaches
- ☐Head Injury *(history of)*
- ☐Hearing Loss
- ☐Hoarseness
- ☐Loss of Smell
- ☐Nasal Congestion
- ☐Nose Bleeds
- ☐Post Nasal Drip
- ☐Rhinorrhea *(runny nose)*
- ☐Sinus Infections
- ☐Snoring
- ☐Sore Throats
- ☐Tinnitus *(ringing in the ears)*
- ☐TMJ Disorder

Cardiovascular:
- ☐None
- ☐Angina *(chest pain or discomfort)*
- ☐Chest Pain
- ☐Claudication *(leg pain or achiness)*
- ☐Heart Murmur
- ☐Heart Problems
- ☐Orthopnea *(difficulty breathing while lying)*
- ☐Palpitations *(irregular or forceful heart beat)*
- ☐Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐Shortness of Breath
- ☐Swelling of Leg*(s)*
- ☐Ulcers
- ☐Varicose Veins

Gastrointestinal:
- ☐None
- ☐Abdominal Pain
- ☐Belching
- ☐Black, Tarry Stools
- ☐Constipation
- ☐Diarrhea
- ☐Difficulty Swallowing
- ☐Heartburn
- ☐Hemorrhoids
- ☐Indigestion
- ☐Jaundice *(yellowing of the skin)*
- ☐Nausea
- ☐Rectal Bleeding
- ☐Abnormal Stool Caliber *(quality)*
- ☐Abnormal Stool Color
- ☐Abnormal Stool Consistency
- ☐Vomiting
- ☐Vomiting Blood

Respiration:
- ☐None
- ☐Asthma
- ☐Coughing up blood
- ☐Shortness of Breath
- ☐Sputum Production
- ☐Wheezing

Endocrine:
- ☐None
- ☐Cold Intolerance
- ☐Diabetes
- ☐Excessive Appetite
- ☐Excessive Hunger
- ☐Excessive Thirst
- ☐Frequent Urination
- ☐Goiter
- ☐Hair Loss
- ☐Heat Intolerance
- ☐Unusual Hair Growth
- ☐Voice Changes

Skin:
- ☐None
- ☐Changes in Nail Texture
- ☐Changes in Skin Color
- ☐Hair Growth
- ☐Hair Loss
- ☐Hives
- ☐Itching
- ☐Paresthesia (numbness, prickling, or tingling)
- ☐Rash
- ☐History of Skin Disorders
- ☐Skin Lesions or Ulcers
- ☐Varicosities

Nervous System:
- ☐None
- ☐Dizziness
- ☐Facial Weakness
- ☐Headaches
- ☐Limb Weakness
- ☐Loss of Consciousness
- ☐Loss of Memory
- ☐Numbness
- ☐Seizures
- ☐Sleep Disturbance
- ☐Slurred Speech
- ☐Stress
- ☐Strokes
- ☐Tremors
- ☐Unsteadiness of Gait

Allergy:
- ☐None
- ☐Anaphylaxis *(history of)*
- ☐Food Intolerance
- ☐Itching
- ☐Nasal Congestion
- ☐Sneezing

Hematology:
- ☐None
- ☐Anemia
- ☐Bleeding
- ☐Blood Clotting
- ☐Blood Transfusion*(s)*
- ☐Bruises easily
- ☐Fatigue
- ☐Lymph Node Swelling

Psychological:
- ☐None
- ☐Anhedonia *(inability to experience joy or enjoy life)*
- ☐Anxiety
- ☐Appetite Changes
- ☐Behavioral Change*(s)*
- ☐Bipolar Disorder
- ☐Confusion
- ☐Convulsions
- ☐Depression
- ☐Insomnia
- ☐Memory Loss
- ☐Mood Change*(s)*

Female:
- ☐None
- ☐Birth Control Therapy
- ☐Breast Lumps / Pain
- ☐Burning Urination
- ☐Cramps
- ☐Frequent Urination
- ☐Hormone Therapy
- ☐Irregular Menstruation
- ☐Urine Retention
- ☐Vaginal Bleeding
- ☐Vaginal Discharge

Male:
- ☐None
- ☐Burning Urination
- ☐Erectile Dysfunction
- ☐Frequent Urination
- ☐Hesitancy or Dribbling
- ☐Prostate Problems
- ☐Urine Retention

Patient Signature: ______________________________________

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: ________________________ __________

Doctor Signature Date