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

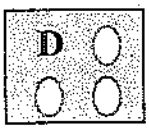
Type of Accident: ☐ Motor Vehicle ☐ Work ☐ Slip/Fall ☐ Other _____

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 >>>>>

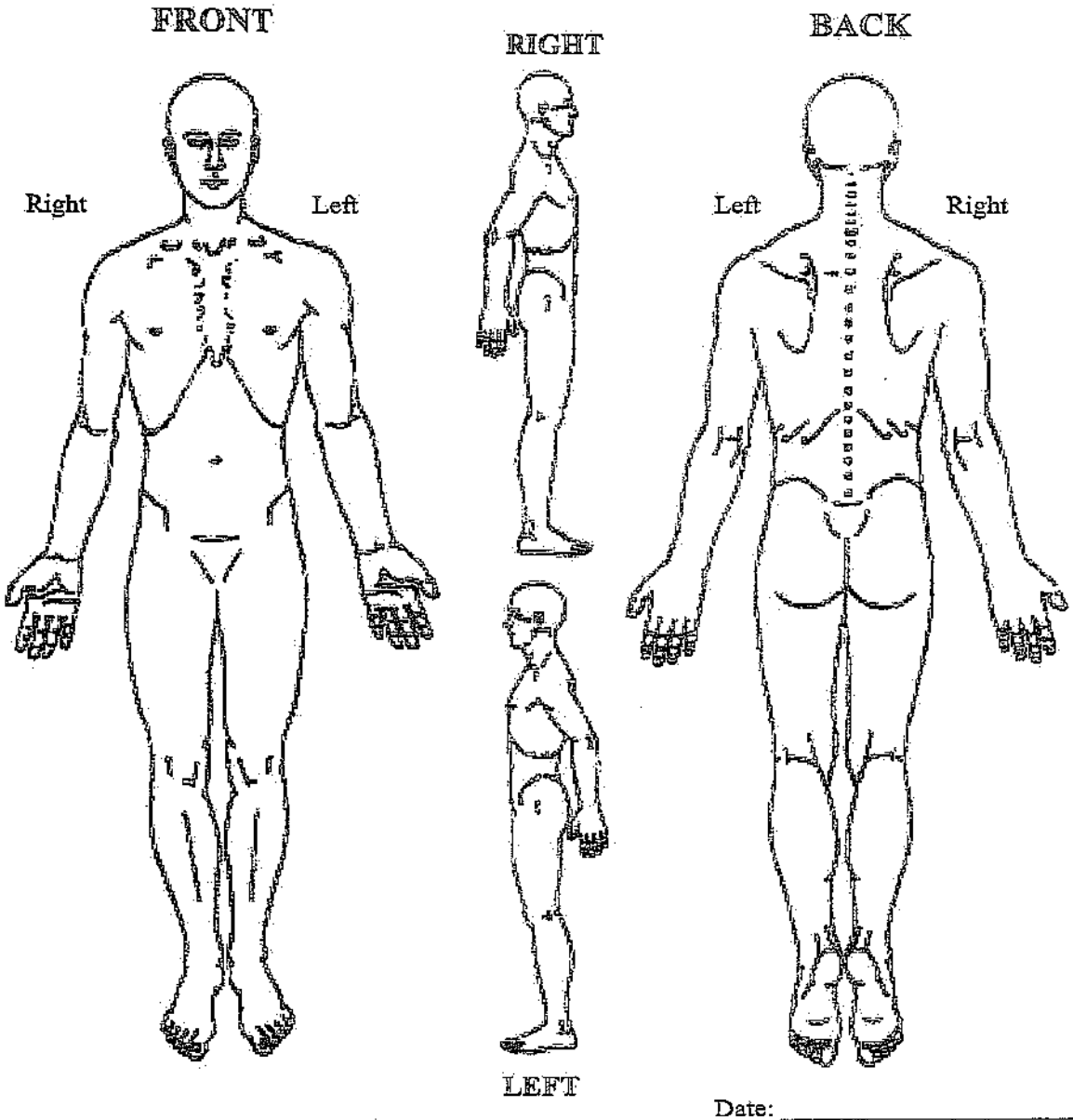
Numbness ═══

Pins and Needles oooo

Burning X X X X

Sharp/Stabbing / / / / /

Throbbing ~~~~~



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