MACK
FAMILY CHIROPRACTIC

**Name**_____ **Nickname**_____

**Address**_____ **City**_____ **State**_____ **Zip**_____

**Cell Phone**_____ **Home Phone**_____ **Work Phone**_____

**Home Email**_____ **Work Email**_____

**Emergency Contact**_____ **Contact Phone**_____

**Date of Birth**_____ **Age**_____ **Gender** ❑ Male ❑ Female ❑ Unspecified

**Marital Status** ❑ Single ❑ Married ❑ Other **SSN**_____

**Employment Status** ❑ Employed ❑ Self Employed ❑ Retired ❑ Student ❑ Other

**Occupation**_____ **Employer**_____ **Employer Phone**_____

**Do you have insurance?** ❑ Yes ❑ No **Insurance Name**_____

**Primary insured?** ❑ Yes ❑ No **If no, primary insured name and relationship to self**_____

**Family Physician**_____ **Physician Phone**_____

**Current medications, including Over the Counter:** **No current medications check here:** ❑

**1)** _____ **5)** _____

**2)** _____ **6)** _____

**3)** _____ **7)** _____

**4)** _____ **8)** _____

**Allergies you have to medications, foods or environment:** **No known allergies check here:** ❑

**1)** _____ **5)** _____

**2)** _____ **6)** _____

**3)** _____ **7)** _____

**4)** _____ **8)** _____

**Have you had any surgeries or hospitalizations?** ❑Yes ❑No If yes, please list:_____

**FAMILY HISTORY:** Please mark all conditions that you **S=Self** or your family **F=Family** have had.

| S | F | | S | F | | S | F | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Alcoholism | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stroke |
| ☐ | ☐ | Anemia | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Asthma | ☐ | ☐ | Liver Disease | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Cancer | ☐ | ☐ | Hepatitis | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Lung Disease | ☐ | ☐ | High Cholesterol |
| ☐ | ☐ | Drug Abuse | ☐ | ☐ | Mental Illness | ☐ | ☐ | HIV / Immune Disease |
| ☐ | ☐ | Depression | ☐ | ☐ | Osteoarthritis | ☐ | ☐ | Other_____ |
| ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ | Osteoporosis | | | |

**HEALTH HISTORY:** Please mark **C=Current P=Past**. Leave blank if N/A.

| C | P | | C | P | | C | P | | C | P | | C | P | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Fever | ☐ | ☐ | Infections | ☐ | ☐ | Congestion | ☐ | ☐ | Painful cycles | ☐ | ☐ | Numbness |
| ☐ | ☐ | Fatigue | ☐ | ☐ | HIV / AIDS | ☐ | ☐ | Sinus pain | ☐ | ☐ | Ovarian cysts | ☐ | ☐ | Tingling |
| ☐ | ☐ | Weight gain | ☐ | ☐ | Freq. Urination | ☐ | ☐ | Low libido | ☐ | ☐ | Nausea | ☐ | ☐ | Pinched nerve |
| ☐ | ☐ | Weight loss | ☐ | ☐ | Excessive thirst | ☐ | ☐ | Infertility | ☐ | ☐ | Liver disease | ☐ | ☐ | Concussion |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Eye pain | ☐ | ☐ | Loss muscle | ☐ | ☐ | Constipation | ☐ | ☐ | Memory loss |
| ☐ | ☐ | Joint pain | ☐ | ☐ | Vision change | ☐ | ☐ | ED | ☐ | ☐ | Diarrhea | ☐ | ☐ | Dizziness |
| ☐ | ☐ | Neck pain | ☐ | ☐ | Ear Ringing | ☐ | ☐ | Rashes | ☐ | ☐ | Indigestion | ☐ | ☐ | Tremors |
| ☐ | ☐ | Back pain | ☐ | ☐ | Difficult Hearing | ☐ | ☐ | Redness | ☐ | ☐ | Bloating | ☐ | ☐ | Recent falls |
| ☐ | ☐ | Swelling | ☐ | ☐ | Painful urination | ☐ | ☐ | Psoriasis | ☐ | ☐ | Abdominal Pain | ☐ | ☐ | Chest Pain |
| ☐ | ☐ | Weakness | ☐ | ☐ | Incontinence | ☐ | ☐ | Eczema | ☐ | ☐ | Blood in Stool | ☐ | ☐ | Palpitations |
| ☐ | ☐ | Osteoporosis | ☐ | ☐ | Blood in Urine | ☐ | ☐ | Trauma | ☐ | ☐ | Food Intolerance | ☐ | ☐ | Swollen ankles |
| ☐ | ☐ | Rheumatism | ☐ | ☐ | Kidney disease | ☐ | ☐ | Headaches | ☐ | ☐ | Cough | ☐ | ☐ | Calf Pain |
| ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Kidney stones | ☐ | ☐ | TMJ | ☐ | ☐ | Short of breath | ☐ | ☐ | Heart problems |
| ☐ | ☐ | Anemia | ☐ | ☐ | Runny nose | ☐ | ☐ | Anxiety | ☐ | ☐ | Wheezing | ☐ | ☐ | Aneurysm |
| ☐ | ☐ | Blood Thinners | | | | ☐ | ☐ | Depression | ☐ | ☐ | Asthma | ☐ | ☐ | COPD |

**Who referred you to our office** (Please be as detailed as possible):_____

_____

**Have you ever had chiropractic care** ❑ Yes ❑ No **Dr. Name**_____ **Date of last visit**_____

**If you are experiencing any pain (neck pain, mid back pain, low back pain, etc), health problems, symptoms, and/or complaints, please list in order of severity:**

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

1. **On the scale below, please circle the SEVERITY of your MAIN COMPLAINTS at their WORST:**

| | *Mild* | | | | *Moderate* | | | | *Severe* | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

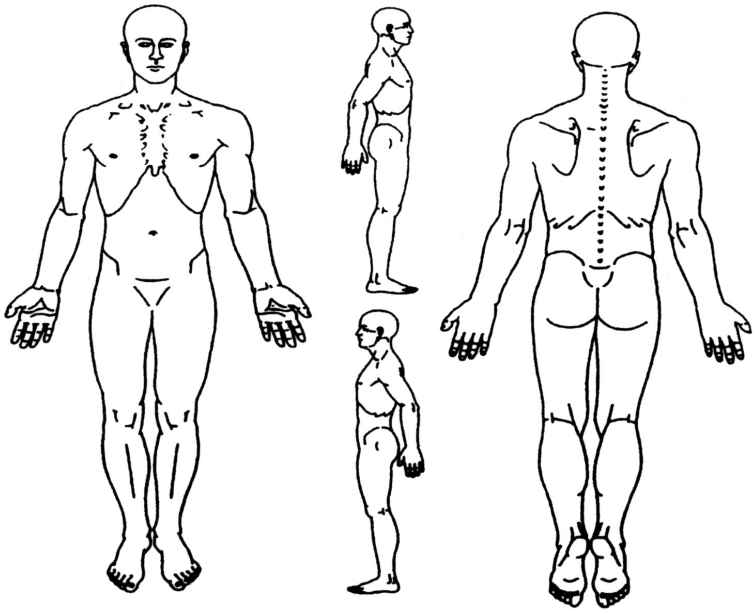
2. **On the scale below, please circle the PERCENTAGE OF TIME you experience your Main Complaints:**

| | *Occasional* | | | *Intermittent* | | | *Frequent* | | | *Constant* |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |

3. **Have these problems been getting** ❑worse ❑staying the same
4. **Have you experienced these complaints while working?** ❑Yes ❑No If yes, please describe what activities at work may be causing you these complaints:_____
5. **Are there other activities, incidents, or events outside of work that may have caused these complaints?** ❑Yes ❑No If yes, please explain:_____
6. **Have you at any time ever suffered a work injury?** ❑Yes ❑No If yes, date of injury:_____
7. **Have you been in an auto accident in the last 12 months?** ❑Yes ❑No If yes, date of accident:_____

8. **On the diagram below, show where you are experiencing ALL present complaints using the following letters:**

**A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T**: tingling **S:** sharp pain



The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). We would like to know how much your health condition is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

**PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES**. 0 means no disability at all, and 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely **able** to function — Totally **unable** to function

1. **FAMILY/HOME RESPONSIBILITIES:** activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc) _____
2. **RECREATION:** hobbies, sports, and other similar leisure time activities _____
3. **SOCIAL ACTIVITY:** activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions _____
4. **OCCUPATION:** activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____
5. **SELF CARE:** activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc) _____
6. **LIFE SUPPORT ACTIVITY:** basic life supporting behaviors such as eating, sleeping, and breathing _____

**Patient Signature**_____ **Date**_____