

Cornerstone Chiropractic

Thank you for choosing our practice for your Chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help! Please print clearly and fill in completely.

Name _____ Nickname _____ Date _____

Home Address _____ Apt. # _____

City _____ State _____ Zip _____ Preferred Language _____

Home Phone _____ Cell Phone _____ Email _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Date of Birth _____ Age _____ Male Female ♦ Single Married Divorced Widowed

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other / I decline to answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Student: Full time Part time Non-student Social Security # _____

Employer _____ Occupation _____ Full time Part time

Employer's Address _____ City, State, Zip _____

Name of Spouse _____ Spouse's Birth Date _____

Spouse's Employer _____ Social Security# _____

Person to contact in case of Emergency: _____ Phone _____

Medical Doctor Name and Clinic _____ Phone _____

Would you like us to send your doctor an initial report of our Chiropractic findings? _____

How did you hear about our clinic? _____

Have you ever been to a Chiropractor before? Yes No If yes, Doctor's Name _____

Date of last Chiropractic Visit _____ Reason for Care _____

Date of last Chiropractic X-rays _____ How long were you under care? _____

Are other family members under Chiropractic care? _____

Reason for this visit: _____

Is this related to: Auto Accident Employment Accident Other Accident

Name and address of other doctor(s) who have treated you for this condition: _____

Please mark the areas of your pain on the diagram below. Use the following letters to indicate the type and location of your pain.

A=Ache

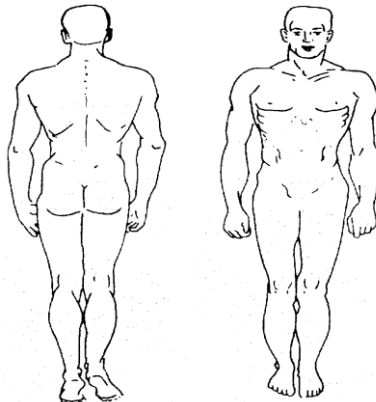
B=Burning

P=Pain

S=Stabbing

N=Numbness

O=Other



Review of Systems:

Check only those conditions that currently apply to you. **Underline** any conditions you have had in the past.

General:	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Weakness
Skin:	<input type="checkbox"/> Skin condition	<input type="checkbox"/> Dryness	<input type="checkbox"/> Rashes/Itching	<input type="checkbox"/> Hair/nail changes
Head:	<input type="checkbox"/> Headache	<input type="checkbox"/> Migraine	<input type="checkbox"/> Head injury	<input type="checkbox"/> Concussion
Ears:	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Ear infection	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Drainage
Eyes:	<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Pain/redness	<input type="checkbox"/> Blurry/double vision
Nose:	<input type="checkbox"/> Allergies	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sinus pain	<input type="checkbox"/> Congestion/itching
Throat:	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Non healing sores	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Bleeding from mouth
Neck:	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Pain	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Lumps
Respiratory:	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Painful breathing	<input type="checkbox"/> Cough/cough up blood
Cardiovascular:	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Chest pain	<input type="checkbox"/> High blood pressure
Gastrointestinal:	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Constipation/Diarrhea
Genitourinary:	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Female problems	<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Difficulty urinating
Musculoskeletal:	<input type="checkbox"/> Muscle or joint pain	<input type="checkbox"/> Muscle spasm	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Swollen/red joints
Neurologic:	<input type="checkbox"/> Seizures	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Numbness/tingling
Hematologic:	<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Clotting problems
Endocrine:	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Sweating	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Heat/cold intolerance
Psychiatric:	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Psychiatric disorder
Other:	<input type="checkbox"/> Allergies	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Disc problems	<input type="checkbox"/> Cold hands/feet
Other:	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/AIDS

Medical and Family History:

List current medications and the condition you are taking it for: (Include regularly used over the counter drugs)

Medication _____ for _____ Dose and freq. _____

Medication _____ for _____ Dose and freq. _____

Medication _____ for _____ Dose and freq. _____

Medication Allergies/adverse reactions _____

List past surgeries and dates _____

List past accidents/traumas and dates _____

List any X-rays you have had in the last 2 years _____

List any diseases/conditions of family members (heart disease, stroke): _____

Females: Are you pregnant? Yes No Date of last period _____ Birth control pills Yes No

Name and Age of Children _____

Social History and Daily Habits:

Do you sleep on your: Back Right Side Left Side Stomach

Do you exercise? Yes No Type of exercise _____ Frequency _____

Smoking status (check one): Every day smoker Occasional smoker Former smoker Never smoked

Do you drink alcohol? Yes No Frequency and Amount _____

Do you drink coffee/tea/cafeinated beverages? Yes No Quantity _____

What do your daily work habits include? (Ex. sitting, standing, light labor, heavy labor, computer work)

Hobbies: _____

I understand the above and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my health status.

Patient Signature _____ Date _____