Chaparral Family Chiropractic
7908 East Chaparral Rd. B109
Scottsdale, AZ 85250

PATIENT INFORMATION

DATE:_____

NAME:_____ SS#_____

DATE OF BIRTH:_____ AGE:_____ SEX:_____

MARITAL STATUS:_____ SPOUSE NAME:_____
NUMBER OF CHILDREN:_____ AGES: _____

ARIZONA ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
HOME PHONE: _____ CELL PHONE:_____
E-MAIL ADDRESS: _____

MAY WE CALL YOU AT WORK? Y / N
WORK PHONE:_____ EXT_____
EMPLOYER: _____
ADDRESS:_____
OCCUPATION:_____

OUT OF STATE ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____

BILLING INFORMATION

RESPONSIBLE PARTY: SELF_____ SPOUSE _____
INSURANCE TYPE: AUTO_____ WORK COMP_____ HEALTH_____
CARRIER NAME: _____

PLEASE CHECK HOW YOU WERE REFERRED

PATIENT _____ THEIR NAME _____
INTERNET _____ INSURANCE _____ DEX _____ SCOTTSDALE PHONE BOOK _____
YELLOWBOOK _____ SIGN/LOCATION _____ WEBSITE _____

SIGN: _____ DATE: _____

PATIENT HISTORY AND INJURY INFORMATION

WHEN DID YOU FIRST NOTICE YOUR PAIN? _____
WHEN DID YOU FIRST SEE A DOCTOR? _____
WHAT IS YOUR MAJOR COMPLAINT TODAY? _____

WHERE IS YOUR PAIN LOCATED?

LEFT	RIGHT			
☐	☐	BUTTOCK	☐ LOW BACK	☐ GROIN
☐	☐	THIGH	☐ MID BACK	☐ HEAD
☐	☐	CALF	☐ UPPER BACK	☐ NECK
☐	☐	FOOT/ ANKLE	☐ FACE	☐ CHEST
☐	☐	SHOULDER	☐ ABDOMEN	
☐	☐	ARM	☐ OTHER _____	
☐	☐	HAND/ WRIST		

PLEASE CHECK THE WORDS THAT BEST DESCRIBE YOUR PAIN:

☐ BURNING	☐ ACHING	☐ SHOOTING
☐ SHARP	☐ THROBBING	☐ OTHER_____

WHAT TIME OF DAY IS YOUR PAIN AT ITS WORST?

☐ MORNING UPON ARISING ☐ LATER IN THE MORNING ☐ AFTERNOON ☐ EVENING
☐ BED TIME ☐ NIGHT (DURING SLEEPING HOURS)
☐ ALWAYS THE SAME ☐ VARIES, but is not worse at any particular time

DO YOU HAVE ANY OF THE FOLLOWING:

☐ NUMBNESS	☐ COLDNESS	☐ SKIN DISCOLORATION
☐ TINGLING	☐ INCREASED SWEATING	☐ BOWEL PROBLEMS
☐ WEAKNESS	☐ MUSCLE SPASM	☐ BLADDER PROBLEMS

WHAT MAKES YOUR PAIN WORSE?

☐ COUGHING	☐ LYING DOWN	☐ BENDING BACKWARD
☐ SNEEZING	☐ WALKING ON LEVEL	☐ PHYSICAL ACTIVITY
☐ STANDING	☐ WALKING UP HILL	☐ SEXUAL ACTIVITY
☐ SITTING	☐ BENDING FORWARD	☐ OTHER _____

WHAT MAKES YOUR PAIN BETTER?

☐ RELAXATION	☐ MEDICINE	☐ CHIROPRACTIC TREATMENT
☐ SITTING	☐ WALKING	☐ OSTEOPATHIC MANIPULATION
☐ STANDING	☐ BIO-FEEDBACK	☐ BED REST
☐ LYING DOWN	☐ TENS	☐ TRACTION
☐ HEAT	☐ ACUPUNCTURE	☐ PSYCHOTHERAPY

Have you been hospitalized for this pain? ☐ Yes, Dates_____ ☐ No

Have you had any of the following:

☐ X-Rays ☐ EMG ☐ MRI
☐ Myelogram ☐ Cat Scan ☐ Bone Scan

List all Medications you currently take: _____

_____

Which of these medications are for pain? _____

_____

List any drug allergy or sensitivity: _____

_____

List any surgery with a date: _____

_____

Have you had any of the following:

☐ Abnormal Bleeding ☐ Diabetes ☐ Hemophilia ☐ Prosthesis
☐ Allergies ☐ Emphysema ☐ Hiatal Hernia ☐ Recent infection
☐ Arthritis ☐ Epilepsy or Seizures ☐ High Blood Pressure ☐ Rheumatic Fever

☐ Asthma ☐ Glaucoma ☐ Intestinal Disease ☐ Stroke
☐ Cancer ☐ Headache ☐ Kidney Disease ☐ TB
☐ Chemotherapy ☐ Heart Attack ☐ Lung Disease ☐ Thyroid Disease
☐ Cough ☐ Heart Disease ☐ Pacemaker ☐ Ulcers
☐ Dentures ☐ Heart Valve Disease ☐ Prior injury ☐ Venereal Disease

Has any family member had: ☐ Headache ☐ Epilepsy/Convulsions ☐ Mental disorder

ACCIDENT HISTORY

Date of accident: _____ Location: _____

☐ Motor Vehicle ☐ Work Related ☐ Motorcycle ☐ Bus
☐ vs. Pedestrian ☐ Bicyclist ☐ Slip and Fall

Briefly describe _____

MOTOR VEHICLE ACCIDENT

Were you: ☐ Driver ☐ Passenger ☐ Restrained
If passenger: ☐ Front ☐ Right Rear ☐ Left Rear
Did you strike another vehicle? ☐ Yes ☐ No
Were you struck by other vehicles? ☐ Yes ☐ No
Impact from: ☐ Left ☐ Right ☐ Front ☐ Rear
Were you: ☐ Stopped ☐ Moving ☐ Slowing
Lose consciousness? ☐ Yes ☐ No ☐ How long? _____
Were you braced for impact? ☐ Yes ☐ No
Upon impact did you strike? ☐ Steering wheel ☐ Dashboard ☐ Windshield
☐ Door ☐ Side window ☐ Headrest ☐ Other
If went to hospital, when? ☐ Time of accident ☐ Later that day ☐ Next day ☐ Other
Were traffic citations issued to you? ☐ Yes ☐ No **Other Driver?** ☐ Yes ☐ No

ATTORNEY NAME: _____
ADDRESS: _____
PHONE: _____ **CONTACT PERSON:** _____

WORK RELATED ACCIDENT

Reported Injuries to Employer: ☐ Yes ☐ No **Were you:** ☐ Lifting ☐ Pushing ☐ Pulling___lbs.
Were you wearing brace? ☐ Yes ☐ No **Disability:** ☐ Total ☐ Partial ☐ Restricted duties
Lost time from work? ☐ Yes ☐ No **If yes, give dates:** From _____ To _____