Chandler Chiropractic | 333 N. Dobson Rd., #16, Chandler AZ 85224 | 480.899.9855

Name ______________________________ Address: ______________________________

City ____________________ State __________ Zip __________ Home # ______________

Cell # ____________________ Email ______________________________

SSN ______________ Date of Birth ______________ Age _____ Weight ________ Height ________

Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ # of children _____ Name of spouse (or parent) ______________

Employer ______________________________ Address ______________________________

City ______________ State _____ Zip _______ Work # __________ Occupation ______________

What is the name of your family physician? ______________ City Located? ______________

Have you ever had Chiropractic care? ❑ Yes ❑ No If yes, doctor name: ______________ Date of last visit ________

If you are experiencing any pain (neck, low back, 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? ______________

Has this problem been getting ❑ worse or ❑ Staying the same?
Currently or in the past have you ever experienced any of these complaints while working? ❑ Yes ❑ No If yes, please describe the activities at work may be causing these complaints: ______________________________

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ❑ Yes ❑ No
If yes, please explain ______________________________

Have you at any time in the past ever suffered a work injury? ❑ Yes ❑ No If yes, what is the date of injury? ______________

Do you have an attorney representing you for this work injury ? ❑ Yes ❑ No If yes, who is your attorney? ______________

Have you been involved in an auto accident in the last 12 months? ❑ Yes ❑ No If yes, date of auto accident? ______________

Do you have an attorney representing you for this auto accident? ❑ Yes ❑ No If yes, who is your attorney? ______________

How many other passengers were in the car with you? ______________________________

List other doctors consulted for these conditions: 1. ______________ 2. ______________

If due to an auto accident, what is the name of your auto insurance company? ______________

Have you ever had any surgeries or hospitalizations? ❑ Yes ❑ No If yes, please list ______________

Please list any current or past injuries and illnesses not listed above ______________

Please check all medications (over the counter and/or prescribed) you are currently taking ❑ Asprin/tylenol ❑ Pain killers ❑ Insulin ❑ Muscle Relaxers ❑ Birth Control ❑ Sleeping pills ❑ Anti-depressants ❑ Other ______________

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). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) 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.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 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).

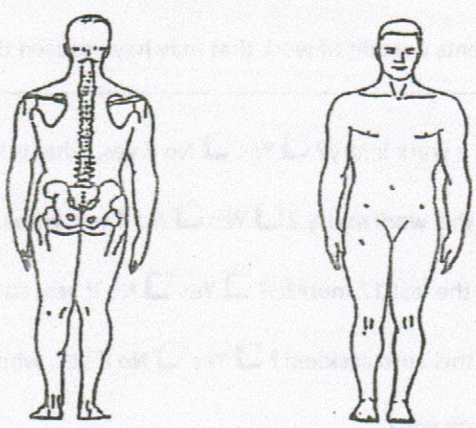
0 1 2 3 4 5 6 7 8 9 10

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. ______

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ ______

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature ______________________________ Date ______________