Laura Freeman D.C. Chris Freeman D.C.
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Name ____ **Date** ________________________
Address _______________________ **City** _________________ **State** ____ **Zip code** ________ **Male / Female**
Phone: (Home) ________________________ **(Cell)** _____________________ **(Work)** _____________________
Date of Birth _____/_____/_____ **Age** ______
Occupation _______________________________ **Employer** ____
E-mail Address ____

Marital status **S / M / W / D** **Name of spouse** ____
Number of pregnancies ____ **Number of children** ____
Are there any diseases in your family? Diabetes / Heart Disease / Cancer Other ___________________
____

Emergency Contact (nearest relative, not spouse) ___________________________**Phone** ________________
How would you like to be verbally addressed? ____
Have you had chiropractic care before? __________ **When?** ____

Previous Surgeries (dates) ____
Previous Fractures (dates) ____
Serious Illnesses (dates) ____
Worker's Comp./Personal Injuries (date, treatment) ____
Injuries to head, neck or back ____

Current Medications ____
Known medication allergies ____
Known food/environmental allergies ____
Current over the counter medications/supplements ____

Social Habits ☐Tobacco ☐Previous Smoker ☐Alcohol (___drinks/day/wk/mo) ☐Coffee (___cup/day)
How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you feel your health is: ☐ Getting better ☐ Getting worse ☐ Staying the same
Have you gained or lost any weight in the past year? Yes / No If yes, explain __________________

What is the name and location of your family doctor? ____

Other Doctors seen for this condition:
Dr _____________________ Specialty _____________________ Tests Done _____________________
Do you currently see this doctor? Yes / No Did treatment help? Yes / No

Whom may we thank for referring you? ____
May we send them a personal "thank you" for telling someone about our office? **Yes / No**

Signature (for the referral thank you*)

____
*Health information will not be released in the 'thank you' referral letter.

INDIAN MEADOWS CHIROPRACTIC CENTER

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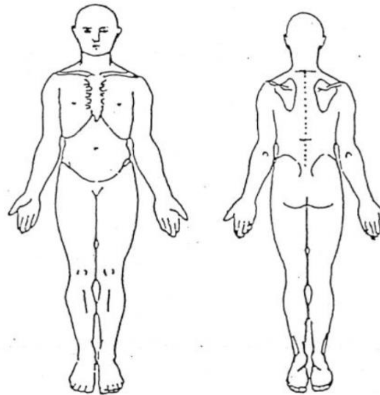
What is your present complaint: ______________________________

Is this condition due to: ☐ Auto accident ☐ Work injury ☐ Other accident ☐ Illness ☐ Unknown cause

How did your problem begin?______________________________

Have you experienced this before: Yes / No (outcome): ______________________________

Indicate the location of the Pain:



Office Use Only:
Height ________'________"
Weight __________ lbs.
Seated BP (L / R) ________/________

What is your current pain level? (no pain) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst pain imaginable)

Is the pain: Getting Better Worse Staying the Same Varies

What is Your Pain Intensity? Minimum Mild Moderate Severe Unbearable None

Can you describe the pain? ( ) Burning ( ) Dull Ache ( ) Numb ( ) Radiating Pain ( ) Sharp
( ) Shooting ( ) Stabbing ( ) Tightness ( ) Tingling ( ) Throbbing

What makes the pain better? Acupuncture Chiropractic Heat Ice Massage Nothing
Medication Stretching Physical Therapy Other: ________________

What makes the pain worse? Sitting Standing Riding in a car Bending Walking
Twisting Lying down Lifting Other: _____________

Expectations: Become pain free Explain my condition Learn to care for this on my own
Reduce Symptoms Resume Normal Activity

How often do you feel the pain? Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

Have you noticed any changes in bowel or bladder function? Yes / No

Any fever, chills, dizziness associated with the symptoms? Yes / No

Do you take any prescription drugs? Yes / No

( ) Anti-inflammatory ( ) Muscle relaxers ( ) BP Meds ( ) Pain Meds
( ) Cholesterol Meds ( ) Birth control ( ) Allergy Meds ( ) Thyroid Meds
( ) Headache Meds ( ) ADD/ADHD Meds ( ) Nerve Pills ( ) Diabetes Meds
( ) Osteoporosis Meds ( ) Depression Meds ( ) Other: _______________

Do You have Any Other Health Concerns: ______________________________