INDIAN MEADOWS
CHIROPRACTIC CENTER

Laura Freeman D.C. Chris Freeman D.C. Emmaline Miller D.C.
7399 SR 366 Huntsville, OH 43324
P: 937-842-2220 F: 937-842-2227 www.indianmeadowschiro.com

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** _____
Emergency Contact (nearest relative, not spouse) _____**Phone** _____
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 _____

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)
Have you gained or lost any weight in the past year? Yes / No If yes, explain _____

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.

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Patient Name: _____ Date: _____

What is your present complaint: _____

When did your problem begin? _____

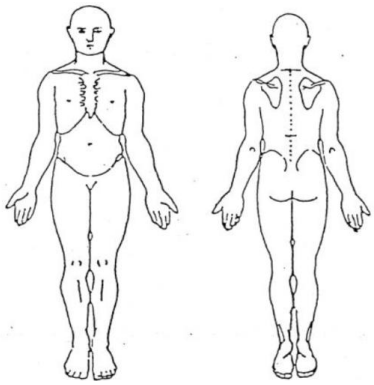
Is this condition due to: ☐ Auto accident ☐ Work injury ☐ Other accident ☐ Illness ☐ Unknown cause

How did your problem begin?_____

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

Did it start: ( ) Gradually ( ) Immediately

Indicate the location of the Pain:



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

What is Your Pain Intensity? Minimal Slight Mild Moderate Severe None

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

Can you describe the pain?
( ) Dull ( ) Sharp ( ) Aching ( ) Shooting ( ) Spasm
( ) Throbbing ( ) Burning ( ) Numbing ( ) Tingling ( ) Tightness
( ) Radiating

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: _____

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: _____