Name: ______________________________ Date: ____________

Address: ____

City: ______________________________ State: ______ Zip: ____________

Cell Phone: ________________ Home: ________________ Work: ________________
*please circle your preferred contact number

E-mail: ____

Would you like to be added to our (e)mailing list to receive occasional Healthy Tips? ☐ Yes ☐ No

Date of Birth: ______________ Age: ______ Marital/Partnership Status: ______________

Number of Children: ________ Name(s): ______________________________

Social Security Number: ________-______-________

Emergency Contact: ______________________ Phone: ______________________

Occupation: ______________ Employer: ______________________________

Address: ____

Whom can we thank for referring you to Progressive Chiropractic? ______________________

Why are you seeking care in the office?
☐ To get out of pain
☐ Do not know
☐ To experience a new degree of health and healing
☐ To be more connected with my body and self
Other: ______________________

Have you ever been to a NUCCA Practitioner in the past? ☐ Yes ☐ No

What was your experience? ____

Have you ever been to any other type of Chiropractor in the past? ☐ Yes ☐ No

What was your experience? ____

Are you insured by Medicare Part B? ☐ Yes ☐ No If Yes, what is your Medicare Number ____________

Have you transferred your Medicare Coverage to a Medicare HMO or Advantage Plan? ☐ Yes ☐ No

If Yes, Please provide the following: Member ID ____________ Group Number ____________

Do you have a Secondary/Supplemental MC Plan? ☐ Yes ☐ No Member ID__________ Group #________

Who carries your Insurance Policy? ☐ Self ☐ Spouse ☐ Parent

How Can We Help?

What specific condition(s) or symptom(s) bring you into the office today? ____________________

____

☐ I have no complaints. I am here for a Wellness Check-up.

This condition is a result of: ☐Motor Vehicle Accident ☐Work Injury ☐Other: __________

Have you done anything or sought treatment for this situation or condition? If so, what was *done* and what were you *told?*

____ Did it seem to work? ☐ Yes ☐ No

When did you first notice your symptoms? ______________________________

How extreme are you current symptoms? 0 ------------------------------------5------------------------------------10

Absent Uncomfortable Agonizing

Please Circle the areas on the Illustration

"o" for the current condition

"x" for conditions experienced in the past

What does it feel like?

☐Numbness ☐Tingling ☐Stiffness

☐Dull ☐Aching ☐Cramps

☐Nagging ☐Sharp ☐Burning

☐Shooting ☐Throbbing ☐Stabbing

Other: ______________________________

How often do you feel it? ☐Constant ☐Comes & Goes

How many episodes per day/week/month? __________

How long does an episode last? ______________

Does it affect other areas of your body? ☐ Yes ☐ No

What areas does the pain radiate, shoot, or travel?

____

What makes it better or worse (such as time of day, movements, certain activities)?

____

What makes it better?

____

What else should we know about your current condition? ______________________________

____

In your opinion, what is the *cause* of your current condition? ______________________________

____

Activities of Daily Living

Is this condition currently interfering with your activities of daily living? If yes, please list the activities that are limited or have diminished as a result of this condition.

1. ______________________ 2. ______________________ 3. ______________________

*Examples can include but are not limited to: sitting/standing/walking for a period of time or distance, bending, driving a car, looking over shoulder, household chores, career or work, recreational activities, sleep exercise, etc.

In addition to the main reason for your visit today, what additional health goals do you have?

____

Review of Systems & Past Personal, Family, Social History

Please check the illnesses you have currently or have in the past. (- have had + have now)

☐Aids	☐Alcoholism	☐Allergies	☐Arteriosclerosis
☐Cancer	☐Chicken Pox	☐Diabetes	☐Epilepsy
☐Glaucoma	☐Goiter	☐Gout	☐Heart Disease
☐Hepatitis	☐HIV Positive	☐Malaria	☐Measles
☐Multiple Sclerosis	☐Mumps	☐Polio	☐Rheum Fever
☐Scarlet Fever	☐STD's	☐Stroke	☐Tuberculosis
☐Typhoid Fever	☐Ulcer	☐Other: ______________________	

Have you had any surgeries?

1. Type:	When?	Doctor
2. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems?)

1. Type:	When?	Hospitalized? Yes☐ No ☐
2. Type:	When?	Hospitalized? Yes☐ No ☐

Have you had any x-rays taken?

Area of Body:	When?	Where?

Do you wear orthotics or heel lifts? ☐Yes ☐ No

Current Healthcare Providers

Our goal is to provide you with the best possible care. With your permission, we communicate with your other healthcare providers about the progress you make in this office.

Primary Care Physician

Office Name: ____________________

Provider Name: ____________________

Address: ____________________

Phone Number: ____________________

Comments: ____________________

Dentist

Office Name: ____________________

Provider Name: ____________________

Address: ____________________

Phone Number: ____________________

Comments: ____________________

Chiropractor

Office Name: ____________________

Provider Name: ____________________

Address: ____________________

Phone Number: ____________________

Comments: ____________________

Other Provider

Office Name: ____________________

Provider Name: ____________________

Address: ____________________

Phone Number: ____________________

Comments: ____________________

Other Provider

Office Name: ____________________

Provider Name: ____________________

Address: ____________________

Phone Number: ____________________

Comments: ____________________

Current Medications & Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription & non)

____

____

Please list any nutritional supplements, vitamins, homeopathic remedies you presently take and why:

____

____

Family History

Please list any Past or Present health conditions

Relative	Age	State of Health	Condition
Mother		☐Good ☐Poor	
Father		☐Good ☐Poor	
Sibling 1		☐Good ☐Poor	
Sibling 2		☐Good ☐Poor	

Are there any other hereditary health issues that you know about? ______________________

Stress

Because the accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

Physical stress (falls, accidents, work postures, etc.)

1. ____
2. ____
3. ____

Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

1. ____
2. ____
3. ____

Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

1. ____
2. ____
3. ____

____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient or parent Signature: ______________________________ Date: ________________