HAINESPORT
CHIROPRACTIC

Name: _____ DOB: _____ Age: ____ Gender: M or F
Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Email:_____ SSN: _____
Occupation: _____ Employer: _____
Emergency Contact: _____ Relation: _____ Phone: _____
Health Insurance: _____ Member ID: _____
Height: _____ (Feet/Inches) Weight: _____ (lbs)
Referred to this office by: _____
Purpose of this appointment: _____
Other doctors seen for this condition: Yes___ No___ Who: _____
When did this start: _____ How did this start: _____
Has this condition occurred before: Yes___ No___
Does this interfere with your: (circle) Sleep Work Daily Activities
On a scale from 1-10, 1 being no pain, rate your pain today: _____
What makes it better: _____ What makes it worse: _____
Describe your condition: (circle)
Constant Or Comes & Goes Local Or Radiating
-Numb/Tingling -Stabbing/Sharp -Burning -Ache -Stiff -Other_____
Do you have difficulty: (circle)
-Sitting -Standing -Bending Forward/Backwards -Twisting
-Lifting -Walking -Reaching Overhead -Other_____
Is this related to work or auto accidents: Yes____ No____
Are you in litigation for any accidents: (Auto, Worker's Comp, etc) Yes___ No___
Current Medications: _____
Previous Chiropractic Care: Yes____ No____
-Name & approximate date of last visit: _____
Major Surgery/Operations: _____ Hospitalizations: _____
Is there anything else the Doctor or Staff should know:_____
_____

Signature: _____ Date: _____

Hainesport Chiropractic LLC

2717 Marne Highway. Hainesport, NJ 08036

Family History

Y N Diabetes
Y N High Blood Pressure
Y N Heart Disease
Y N Musculoskeletal Disease
Y N Cancer: _____
Y N Stroke/aneurysm
Y N Osteoporosis
Y N Other: _____

Current General History

Y N Unexplained Wt Change: Inc or Dec
Y N Allergies: _____
Y N Bleeding/Bruising
Y N HIV
Y N Cancer: _____
Y N Insomnia
Y N Other: _____

Endocrine History

Y N Thyroid Condition: Hyper / Hypo
Y N Diabetes
Y N Other: _____

Eye/Ear/Nose/Throat

Y N Eye or Ear Pain
Y N Other Visual Conditions
Y N Change in vision/hearing/taste
Y N Ringing in Ears
Y N Dizziness
Y N Difficulty Chewing/Swallowing

Gastrointestinal System

Y N Anorexia/Bulimia
Y N Constipation/Diarrhea
Y N Nausea/Vomiting
Y N Abdominal Pain/Swelling
Y N Gallbladder Disease
Y N Liver/Pancreatic Disease

Urinary System

Y N Urinary Urgency/Pain
Y N Difficulty holding/expelling
Y N Kidney Disease/Stone/Pain
Y N Prostate Issues
Y N Pelvic Pain

Cardiovascular System

Y N Heart Medications
Y N Past heart or vascular disease
Y N Chest discomfort/pain
Y N Palpitations
Y N Edema
Y N High Blood Pressure
Y N Blood clot/aneurysm/DVT
Y N Sudden calf pain with walking
Y N Other: _____

Skin/Hair/Nails

Y N Skin Cancer
Y N Rashes/itching/lesions
Y N Psoriasis

Neurological System

Y N Headaches
Y N Seizures/epilepsy
Y N Vertigo
Y N Loss of sensation
Y N Head Trauma
Y N Multiple Sclerosis
Y N Vertebral Disc Condition
Y N Anxiety/Bipolar/Depression

Musculoskeletal System

Y N Osteoporosis/Fibromyalgia
Y N Arthritis: _____
Y N Scoliosis
Y N Joint pain/stiffness/swelling
Y N Muscle cramp/soreness/pain
Y N Neck pain
Y N Upper/Mid back pain
Y N Low Back Pain
Y N Shoulder/arm/hand pain
Y N Leg/knee/foot pain
Y N Fractures/dislocation/sprains
Y N TMJ issues

Pulmonary System

Y N Asthma/Shortness of Breath
Y N Apnea
Y N Pneumonia
Y N Cigarette Smoking
Y N Respiratory infections
Y N Other: _____

Implants/Orthotics

Y N Cardiac/Pacemakers
Y N Joint replacement/Pins/Plates/Screws

Diet/Exercise

Y N Consume caffeine
Y N Consume alcohol

Signature_____Date_____