LINDSEY CHIROPRACTIC
AND MASSAGE THERAPY CLINIC (847) 487-1111/ (847) 543-9999

Patient Information

Date:________________

First Name: ___________________________ M.I.: _______ Last Name: ______________________________

S/S #_______-_____-_______ Street Address: ____

Date of Birth: _____/_____/______ City: ______________________________ State: _____ Zip: ____________

Home Phone: (_______) _______-__________ Email Address: ___________________________________

Cell Phone: (_______) _______-__________ *Which Phone # is best to reach you?

Work Phone: (_______) _______-__________ Circle One: Home # Cell # Work #

Circle One: Minor Single Married Divorced Widowed

Spouse's or Parent's Name: ________________________

Your Employer: ________________________________ Your Occupation:___________________________

Employer's Address: ____

Emergency Contact: ________________________ Phone: (_______) _______-__________

Whom may we thank for referring you to us? ____

Pain Drawing

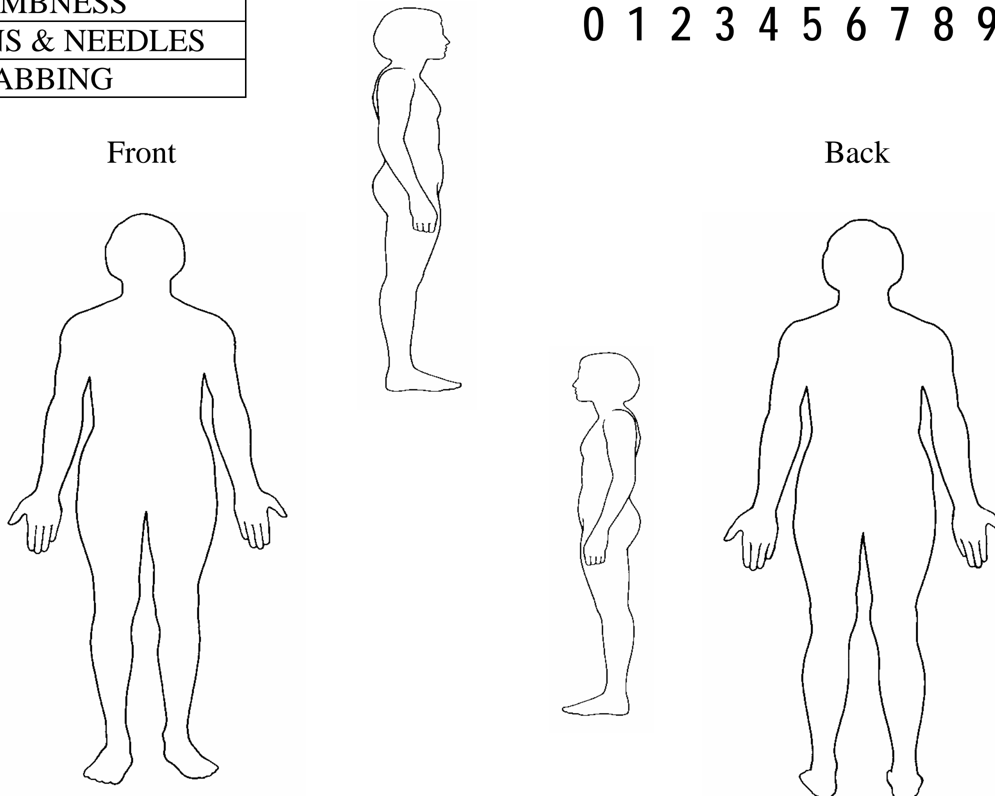
Using the KEY given below, Mark on the drawing the areas of pain and type of pain you are experiencing

KEY	TYPE OF PAIN
A	ACHE/DULL
B	BURNING
N	NUMBNESS
P	PINS & NEEDLES
S	STABBING

CIRCLE YOUR CURRENT PAIN LEVEL:

0 = No Pain 10 = Worst Pain

0 1 2 3 4 5 6 7 8 9 10



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PATIENT HEALTH HISTORY

1. What is your MAJOR COMPLAINT today? ______________________________
2. WHEN did this happen? ______________________________
3. HOW did this happen? ______________________________
4. HAVE you ever seen a Chiropractor? Yes No
5. Describe your pain. Dull achy stiff sharp shooting burning tingling throbbing
   other: ______________________________
6. Does the pain radiate (TRAVEL)? Yes No If yes, WHERE? Arm R/L Hand R/L Leg R/L
   Foot R/L Buttock R/L
7. Do you have any weakness in your arms, hands, or legs? Yes No ______________________________
8. Do you have any recent changes in your bowel or bladder? Yes No ______________________________
9. What makes the pain WORSE? Walking, Standing, Sitting, Bending, Lifting, Trying to Stand Up, Driving, Work, Sports, Sleeping, Coughing, Sneezing, Laughing, Other: ______________________________
10. What makes the pain BETTER? Ice, Heat, Stretches, Sitting, Lying Down, Standing, Walking, Medication:
    ______________________________Other:______________________________
11. Is the pain CONSTANT or does it COME and GO?
12. Is the pain BETTER or WORSE in the morning? BETTER or WORSE in the evening? Is the Pain always the SAME? ______________________________
13. Have you had any recent X-RAYS, MRI'S, CT SCAN, ETC: ______________________________
14. Have you ever had this pain before? Yes No If yes, WHEN and HOW was it treated?______________________________
15. Have you seen any other doctors for this condition? Yes No If yes, WHEN and HOW was it treated?______________________________
16. Is the pain stopping you from doing any of your normal daily activities? Yes No If yes, please describe:
    ____
17. In your immediate family, is there any history of: Cancer, Stroke, Diabetes, Heart Condition, or Other Illnesses:
    ____
18. List any major SURGERIES, past ILLNESSES, TRAUMAS or FRACTURES.

______________________ DATE: ______________ ____________________DATE: ______________
______________________ DATE: ______________ ____________________DATE: ______________
______________________ DATE: ______________ ____________________DATE: ______________
______________________ DATE: ______________ ____________________DATE: ______________

19. Are you pregnant or trying to get pregnant? Yes No
20. Are you RIGHT handed or LEFT?
21. Do you have any OTHER SYMPTOMS you would like to discuss at this time? ______________________________
    ____
22. Please list your MEDICATIONS and what you are taking them for: ______________________________
    ____
23. Please list any ALLERGIES to MEDICATIONS: ______________________________
    ____

Patient Signature: ______________________________ Date: ______________________