GRAND HEALTH CHIROPRACTIC AND WELLNESS CENTER

PATIENT INFORMATION

Last Name:_____ First Name:_____MI:_____

Address:_____Apt/Unit:_____

City: _____State:_____Zip Code:_____

Primary Phone:_____Work Phone:_____Email Address:_____

Social Security Number:_____Birthdate:_____Age:_____Gender: ○Male ○Female

Height: ___ft_____in Weight:_____ Occupation:_____

Employer:_____

How were you referred to Grand Health Chiropractic?

□ Family Member □ Friend □ Doctor □ Internet Search □ Google Ad □ Facebook □ Yelp □ Other_____

Please give us the name of the family member, friend or doctor that referred you:_____

Emergency Contact:_____Phone Number:_____Relationship to the Patient:_____

INTEGRATED CARE

May we share your information in our patient records with your above listed Physician for integrated care? □Yes □No
Family Physician:_____ City:_____State:____Phone:_____
Student Athletes: May we share information related to your case with your coaches or athletic trainer for integrated and coordinated care? □Yes □No School: _____Athletic Trainer: _____

What are your current complaints?_____

When did your problem begin?_____

How did this problem begin?_____

Is your current injury/condition related to an auto/work accident? □ Yes □ No If yes, what is the date of the accident?_____

Please describe your current pain.

□ Sharp □ Dull Ache □ Numb □ Shooting
□ Burning □ Tingling □ Other_____

Since your problem began, is the pain…

□ Increasing □ Decreasing □ Not Changing

How frequent is your pain?

□ Constantly □ Frequently □ Occasionally □ Intermittently

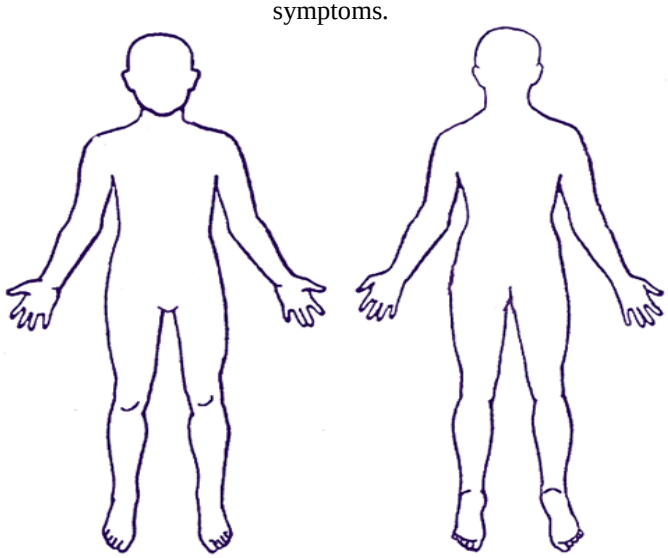
What makes your problem better?_____
_____

What makes your problem worse?_____
_____

What type of care are you interested in?

□Pain relief only
□Healing/correction of current condition
□Optimizing your health/Wellness Care
□All Three

Please mark the location where you have the pain or other symptoms.



Rate the severity of your pain

None Unbearable
0 1 2 3 4 5 6 7 8 9 10

Please list any activities of daily living that your current symptoms are affecting (e.g. playing with kids, gardening, housework, etc):

1. _____ 2. _____

3. _____ 4. _____

Other health care providers consulted for this condition and outcome:

_____

Women: Are you or is there a possibility that you may be pregnant?_____ If yes, what is the due date?_____

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following area? *(Please check boxes to indicate problem areas)*

□Eyes	□Muscles	□Allergies	□Ears, Nose, Mouth, Throat
□Nerves	□Psychological/Emotional	□Heart	□Joints/Bones
□Lungs/Breathing	□Skin	□Intestines/Bowel	□Internal Organs
□Urinary	□Blood	□Prostate/Testicular/Penile	□Gynecological/Menstrual/Breast

Please explain any above **YES** answers: _____

_____

SOCIAL HISTORY:

Recreational Activities (Hobbies):_____

YES	**NO**	
□	□	Do you exercise? _____Times per week
□	□	Do you get 6-8 hours of adequate sleep per night? If no, explain: _____
□	□	Is work stressful to you? If yes, explain: _____
□	□	Is family life stressful to you? If yes, explain: _____
□	□	Do you consume alcohol? If yes, how many drinks per week? :_____
□	□	Do you smoke? If yes, how many packs per day? _____
		If you smoked previously and have quit, when did you quit? _____
□	□	Do you use recreational drugs? If yes, explain: _____

Surgeries:_____

Serious illness or injury:_____

Allergies:_____

Medications taken within the last two months (include over the counter and vitamins):_____

_____

Are there any other issues concerning your health that you would like the doctor to be aware of?_____

_____

Have you had any other significant traumas? (Auto accidents, falls, etc…):_____

_____

Patient Name (Please Print)_____

Name of Person Completing this form_____ **Relationship to the Patient**_____

Signature of patient or person completing this form_____ **Date**:_____