Well Adjusted

Chiropractic and Acupuncture Clinic, p.c.

Patient information

Date_____ Patient Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Emergency contact:_____ Phone:_____
Sex: □ - M □ - F Age:_____ DOB:_____ Marital Status:_____
Occupation:_____ Employer:_____
Spouse's Name and address if not the same as above:
_____

Email address:_____ Can we contact you by □ Phone □ Email □ Mail

Whom may we thank for referring you :_____

Health complaint

Main complaint:_____

When & how did it start?_____

Describe the pain:
□ Sharp □ Dull □ Throbbing □ Aching □ Shooting □ Burning □ Tingling □ Stiff
□ Constant □Intermittent □ Cramps □ Electrical □ Deep □Superficial □ Swollen □ Numb □ Sudden
□ Other _____

What makes the pain worse?
□ Sitting □Standing □ Walking □ Bending □ Standing up □Lying down
□ Lifting □ Coughing □ Sneezing □ Heat □ Cold □ Other _____

What makes the pain better?
□ Sitting □ Standing □ Walking □ Bending □ Standing Up □ Lying Down □ Lifting □ Coughing
□ Sneezing □ Heat □ Cold □ Massage □ Adjustments□ Medicines
□ Other _____

Does it interfere with your:
□ Work □ Sleep □ Daily routine □ Recreation

CONFIDENTIAL