WHITE MOUNTAIN
Chiropractic & Rehabilitation

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PATIENT INFORMATION:

Name:			Date:	Sex: M F
Address:			Birthdate:	Age:
City:	State:	Zip:	Single [ ] Married [ ] Divorced [ ]	
Occupation:			Employer:	
Spouse's Name:			Birthdate:	Age:
Occupation:				
How did you hear about White Mountain Chiro and Rehab?				

CONTACT INFORMATION:

Home Phone:	Cell Phone:	Work Phone:
Email (rehab exercises and appointment reminders):		
In case of emergency, contact:		Relationship:
Home Phone:	Cell Phone:	Work Phone:

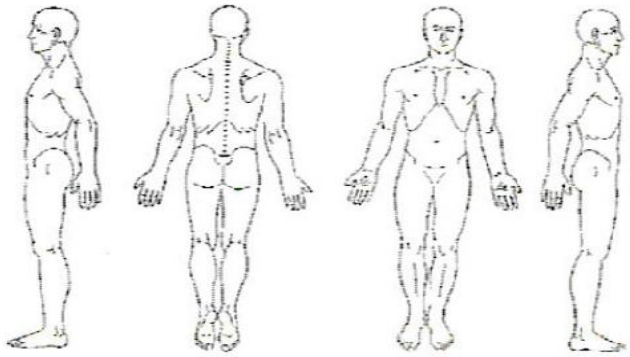
Primary Care Physician:_____Permission to correspond with PCP: Y N

CONDITION:

Chief Complaint / Reason for visit:_____

Please mark on the line below the intensity of your pain:

No Pain ---------- Unbearable



Please mark on the diagram areas of discomfort with the following key:

S = Sharp A = Ache
N = Numbness
B = Burning T = Tingling
► = Shooting O = Other

Date of onset:_____Describe how your symptoms began:_____

On a scale of 1 to 10 [10 being the worst] where is your pain: at its best: _____/10 at its worst: _____/10

(please circle all that apply)

Type of pain: Sharp Dull Aching Stiffness Burning

Numbness Tingling Throbbing Shooting Spasms

Frequency: Constant Frequent Comes and goes Worse in Morning Worse in Evening

What IMPROVES your symptoms: Lying down Sitting Standing Walking
Exercise Inactivity Nothing

Other: _____

What WORSENS your symptoms: Lying down Sitting Standing Walking
Exercise Inactivity Nothing

Other: _____

Does your problem interfere with: Work Hobbies Daily Activity Sleep

Other: _____

Have you received treatment for your current condition? Y N If yes, by whom? _____

Expectation of today's visit: _____

HEALTH HISTORY: Please indicate if you have had any of the following

	Y	N		Y	N		Y	N		Y	N		Y	N
ABNORMAL WEIGHT GAIN			ABNORMAL WEIHGT LOSS			ALCOHOLISM			APPENDICITIS			ARTHRITIS		
ASTHMA			BALANCE PROBLEMS			CANCER			HEAD INJURY			CHICKEN POX		
DIABETES			DIZZINESS			FRACTURES			GOITER			GOUT		
HEART DISEASE / CONDITION			CAR ACCIDENT			HERNIA			HERNIATED DISC			HIGH CHOLESTEROL		
KIDNEY DISEASE			LIVER DISEASE			LOSS OF CONSCIOUSNESS			MIGRAINES			NIGHT SWEATS		
MULTIPLE SCLEROSIS			HIGH BLOOD PRESSURE			OSTEOPEROSIS			PACEMAKER			PARKINSON'S DISEASE		
PINCHED NERVE			PNEUMONIA			PROSTATE DISEASE			PROSTHESIS			PSORIASIS		
RHEUMETOID ARTHRITIS			STROKE			THYROID PROBLEMS			VISUAL DISTURBANCES			TUBERCULOSIS		
TUMORS			ULCERS			BOWEL/BLADDER DSYFUNCTION			BLOOD DISORDER / CLOTS			FIBROMYALGIA		
LONG TERM STEROID USE			LONG TERM ANTIBIOTICS			WEAKNESS IN ARMS/LEGS			ANXIETY / DEPRESSION			OTHER		

_____

_____

Exercise/Physical Activity: None Mild Moderate Heavy

Work: Sitting Standing Heavy Labor

Hospitalizations: _____

Falls: _____ **Car Accident:** _____

_____ _____ _____
Patient Name Patient Signature Date

PHYSICIANS NOTES: