Coon Valley Chiropractic
Patient Introduction Form

First Name	MI	Last Name	Social Security #	Birthdate	Age

Address	City	State	Zip Code

Home Phone #	Cell Phone #	Work Phone #	Email

☐ Male ☐ Female	Marital Status ☐ S ☐ M ☐ D ☐ W	Patient's Occupation	Patient's Employer

Please fill out this line if your insurance is through your spouse.	Spouse's Name	Spouse's Birthdate	Spouse's Employer

Responsible Party For Billing: (Check One) ☐ Self ☐ Spouse ☐ Parent ☐ Work Comp ☐ Personal Injury Insurance

Name of Responsible Party	Address, If Different From Above

When did your symptoms begin?_____ **Describe your discomfort:** _____

_____

Neck Pain_____

_____

Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

Does it radiate to: ☐ head ☐ shoulders ☐ arms ☐ throat

What makes it worse?_____

What makes it better?_____

Headache_____

_____

Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

Describe symptoms: _____

Describe location:_____

Upper Back Pain_____

_____

Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

Does it radiate to: ☐ chest ☐ ribs ☐ sternum ☐ clavicle

What makes it worse?_____

What makes it better?_____

Arm Symptoms_____

_____

Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

Does it radiate to: ☐ neck ☐ shoulder ☐ wrist ☐ hand ☐ finger

What makes it worse?_____

What makes it better?_____

Lower Back Pain_____

_____

Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

Does it radiate to: ☐ abdomen ☐ buttock ☐ hip ☐ leg

What makes it worse?_____

What makes it better?_____

Leg Symptoms_____

_____

Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

Does it radiate to: ☐ thigh ☐ knee ☐ calf ☐ ankle ☐ foot ☐ toes

What makes it worse?_____

What makes it better?_____

Chiropractic Information

Have you ever had chiropractic care? ☐ Yes ☐ No

When?_____

For what reason?_____

Medical Doctor Information

Medical Doctor Name:_____

Clinic:_____

Occupation Information

What do you do at work? _____

How many hours?_____

Have you ever farmed? ☐ Yes ☐ No

When?_____

Have you been in the military? ☐ Yes ☐ No

Have you had any injuries?_____

_____

Surgeries_____

_____

Illnesses_____

_____

Women

Are you pregnant? ☐ Yes ☐ No

When is your due date? _____Number of children_____

Traumas

Falls _____

Broken bones_____

Car accidents_____

Medication & Dosage List (We can make a copy of your list)

_____

_____

Supplement/Vitamin/Mineral List

_____

Required Health Questions for National Health Care

Do you have asthma? ☐ Yes ☐ No Do you live with someone who smoke? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ When did you quit?_____

Do you have diabetes? ☐ Yes ☐ No If yes, do you take medication for it? ☐ Yes ☐ No

What medication do you take for your diabetes?_____ Dosage:_____

Do you suffer from depression? ☐ Yes ☐ No If yes, do you take prescription medication for it? ☐ Yes ☐ No

What medication do you take for depression? _____ Dosage:_____

Day to Day Activities

Describe your exercise routine_____

Describe your stress level. ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Do you consume alcohol? ☐ Yes ☐ No Number per day_____ per week_____

Do you use caffeine? ☐ coffee ☐ soda ☐ black tea ☐ energy drinks # cups/bottles/cans_____per day

Do you drink diet soda? ☐ Yes ☐ No # cups/bottles/cans_____per day

Do you use artificial sweeteners? ☐ Yes ☐ No

Your signature on this sheet gives us permission to treat you at this office. Minors must have a parental signature before treatment can be given.

Signature:_____ Date:_____

Parent/guardian name (print):_____

Parent/guardian signature for minor child_____