Taylor Family CHIROPRACTIC

74 Main St. | Medway, MA 02053

Record # ___________________

Name ______________________________ Today's Date__________ Birthdate __________ Age______

Address ______________________________ City __________________ State _____ Zip _________

Home Phone ______________ Cell Phone ______________ Occupation ______________ Gender ❑ M ❑ F ❑ O

E-Mail ____________________ # of Kids/Ages __________________________

Spouse name ______________ Emergency Contact __________________ Phone Number ________________

Who May We Thank For Referring You To Our Office:____

PRESENT COMPLAINTS (Please fill out in as much detail as possible)

1.____ How long has this been an issue? _________

Is it: ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%) **Worse**: ❑ Morning ❑ Mid-day ❑ Night

❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other __________ ❑ **Pain radiates to:** ______________

❑ Staying the same ❑ Getting worse ❑ Improving **Pain Scale**: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN

Relieved by: ________________________ **Aggravated by:** ________________________________

Previous Episodes: ❑ Yes ❑ No Details: ____

Previous Care for this condition: ❑ Yes ❑ No ________________ **Recent Testing:** ❑ Yes ❑ No ________________

2.____ How long has this been an issue? _________

Is it: ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%) **Worse**: ❑ Morning ❑ Mid-day ❑ Night

❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other __________ ❑ **Pain radiates to:** ______________

❑ Staying the same ❑ Getting worse ❑ Improving **Pain Scale**: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN

Relieved by: ________________________ **Aggravated by:** ________________________________

Previous Episodes: ❑ Yes ❑ No Details: ____

Previous Care for this condition: ❑ Yes ❑ No ________________ **Recent Testing:** ❑ Yes ❑ No ________________

3.____ How long has this been an issue? _________

Is it: ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%) **Worse**: ❑ Morning ❑ Mid-day ❑ Night

❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other __________ ❑ **Pain radiates to:** ______________

❑ Staying the same ❑ Getting worse ❑ Improving **Pain Scale**: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN

Relieved by: ________________________ **Aggravated by:** ________________________________

Previous Episodes: ❑ Yes ❑ No Details: ____

Previous Care for this condition: ❑ Yes ❑ No ________________ **Recent Testing:** ❑ Yes ❑ No ________________

Any other information the doctor should know or you would like the doctor to know.

____

____

____

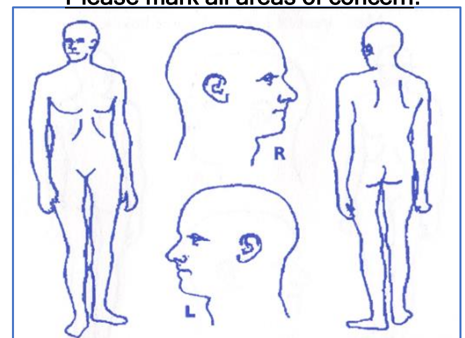
DOCTORS NOTES: ______________________________

____

____

____

Please mark all areas of concern:



Patient/Guardian Signature ____________ Date ________ Doctor Signature ____________ Date ________

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Record # ____________________

Patient Name____ Date __________

PATIENT HISTORY

❑ **NO MEDICAL PROBLEMS - No prior history of any significant medical problems: Initial:______**

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use Packs Daily______ for ____years
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes Type _______	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Lung/Respiratory Conditions ______________
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke/TIA History _____________________
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems _____________________
❑	❑	Vision Problems	❑	❑	Men: Prostate conditions _________________
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems _______________________

❑ ❑ **Other** ____

❑ ❑ **Cancer (please give details):** ____

Women only

Experience painful menstrual cycles: ❑ Yes ❑ No | **Have Irregular Cycle:** ❑ Yes ❑ No | **Breast Implants:** ❑ Yes ❑ No

Are you pregnant: ❑ Yes ❑ No | Are you Nursing: ❑ Yes ❑ No | **Are you on birth control:** ❑ Yes ❑ No

Current Medications: ❑ NONE

____

____

Past Injuries (Include auto collisions and work injuries) and treatment received: ❑ NONE

____

____

Past Hospitalizations and surgeries: PLEASE LIST ANY MEDICAL OR SURGICAL IMPLANTS: ❑ NONE

____

____

FAMILY HISTORY

❑ No known significant family history

❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Blood Disorders ❑ Neurological Problems ❑ Arthritis ❑ Other ________________

Explanation: ____

Is there any other significant family history? ____

Patient/Guardian Signature	Date	Doctor Signature	Date
____________________	________	___________________	_______