Welcome to Richmond Hill Chiropractic

(Please write above line, to the right of the arrowheads)

➢ Last Name | ➢ First Name | ➢ MI | ➢ Birth Date / / | M F Sex | S M W D Marital Status | ➢ Spouse's Name

➢ Address | ➢ City | ➢ State | ➢ Zip

➢ Home Phone | ➢ Work Phone | ➢ Cell Phone | ➢ E-Mail

➢ Your Social Security # | ➢ Your Occupation | ➢ Your Employer's Name | ➢ Your Employer's Address

➢ Your Insurance Plan | ➢ Plan # or Group Name | ➢ Subscriber (insured's) Name | ➢ Insured's ID#

➢ Primary Care Physician (PCP) Name and Address | ➢ PCP Phone #

➢ Your Spouse's Insurance Plan | ➢ Plan # or Group Name | ➢ Subscriber (insured's) Name | ➢ Insured's ID#

Place check-off the box(es) that relate to your current problem(s)

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low Back pain

☐ Other ➢

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began ➢

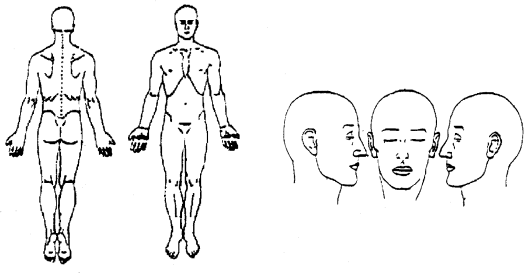
How Problem Began ➢

Circle current level of pain (how you feel today)

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable**

Mark an X on the picture where you have pain or other symptoms



How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

☐ Can you perform your daily activities? ☐ Yes ☐ No Describe any current activity limitations? ➢

➢

Have you had spinal x-rays, MRI, CT Scan? ☐ No ☐ Yes Date(s) taken: ➢

What areas were taken? ➢

Please check off all of the following that apply to you ☐ **None apply**

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Currently Pregnant, # weeks _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	Low/Mid Back Pain
☐	☐	Stroke	☐	☐	Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	Nocturnal Pain (pain at night)
☐	☐	Aortic Aneurysm	☐	☐	Surgeries ➢
☐	☐	Cancer/Tumor	☐	☐	Other ➢
☐	☐	Osteoporosis	☐	☐	Medications ➢
☐	☐	Recent Trauma			

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate.

Patient Signature _____ **Date** _____