Swanson Chiropractic & Acupuncture Clinics

Patient Information

Date:_____

Patient Name (Legal):_____ **Date of Birth:** _____/_____/_____

Nickname (If Any):_____ **Social Security No.:** _____-_____-_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

E-Mail Address:_____ **Health Insurance Company:**_____

Occupation:_____ **Employer:**_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Partnership**

Spouse's Name:_____ **Number of Children:**_____ **Ages of Children:**_____

Emergency Contact:_____ **Contact Phone:**_____

Primary Care Physician:_____ **Clinic:**_____

Have you ever received Chiropractic Care? ☐ **No** ☐ **Yes, Doctor's Name:**_____

Who referred you or how did you find our office? _____

Chiropractic Case History

Major Complaint:_____

Complaint Began When and How? _____

Grade Intensity/Severity of Complaint/Pain: [None] (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) [Worst Possible]

What Daily Activities are affected by the Complaint? _____

Previous Treatment: ☐ **None** ☐ **MD** ☐ **DC** ☐ **PT** ☐ **Heat** ☐ **Ice** ☐ **OTC** ☐ _____

Quality of Complaint/Pain: ☐ **Sharp** ☐ **Stabbing** ☐ **Dull** ☐ **Achy** ☐ **Burning** ☐ **Throbbing** ☐ **Stiff & Sore**

Frequency of Complaint/Pain: ☐ **Off & On** ☐ **Constant** **When is Complaint/Pain the worst?** ☐ **AM** ☐ **PM**

Does the Complaint/Pain Radiate to Any Part of your Body? ☐ **No** ☐ **Yes, Where to?** _____

What Makes it Better? ☐ **Nothing** ☐ **Rest** ☐ **Ice** ☐ **Heat** ☐ **Movement** ☐ **Stretching** ☐ **OTC** ☐ _____

What Makes it Worse? ☐ **Rest** ☐ **Sitting** ☐ **Standing** ☐ **Movement** ☐ **Overuse** ☐ **Stress** ☐ _____

Doctor's Initials

Secondary Complaints:_____

Recent Accidents:_____

Recent Surgeries:_____

Medications:_____

Allergies:_____

What are your goals for care in our office? ☐ **Short-term Relief** ☐ **Long-term Relief** ☐ **Wellness/Preventive Care**

Review of Systems

Please mark all of the following that apply.

Musculoskeletal:	Present	Past
Jaw/TMJ Pain	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Pain in Arm or Elbow	☐	☐
Pain in Wrist or Hand	☐	☐
Rib Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Lower Back Pain	☐	☐
Hip Pain	☐	☐
Pain in Leg or Knee	☐	☐
Pain in Ankle or Foot	☐	☐
Joint Stiffness	☐	☐
Muscle Weakness	☐	☐
Joint Replaced	☐	☐
Arthritis	☐	☐
Broken Bones	☐	☐
Osteoporosis	☐	☐

Other Conditions:	Present	Past
Ear Infections	☐	☐
Colicky Baby	☐	☐
Bed Wetting	☐	☐
Acid Reflux	☐	☐
Torticollis/Wryneck	☐	☐
Whiplash	☐	☐

Neurological:	Present	Past
Headaches	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Pinched Nerves	☐	☐
Stroke	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Epilepsy	☐	☐
Head Injury	☐	☐
Parkinson's Disease	☐	☐

Constitutional:	Present	Past
Weight Loss/Gain	☐	☐
Energy Level Problem	☐	☐
Difficulty Sleeping	☐	☐

Cardiovascular:	Present	Past
Poor Circulation	☐	☐
High Blood Pressure	☐	☐
Aortic Aneurism	☐	☐
Brain Aneurysm	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Heart Attack	☐	☐
Chest Pain	☐	☐
High Cholesterol	☐	☐
Pace Maker	☐	☐
Jaw Pain	☐	☐
Irregular Heartbeat	☐	☐
Swelling of Legs	☐	☐

Endocrine:	Present	Past
Thyroid Disease	☐	☐
Diabetes	☐	☐
Hair Loss	☐	☐
Menstrual Problems	☐	☐
Menopausal	☐	☐

Hematologic/Lymphatic:	Present	Past
Hepatitis	☐	☐
Cancer	☐	☐
Blood Clots	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Fevers/Chills/Sweats	☐	☐

Ears/Nose/Throat:	Present	Past
Tinnitus	☐	☐
Hearing Loss	☐	☐
Balance Problems	☐	☐
Sinus Infection	☐	☐
Nosebleed	☐	☐
Sore Throat	☐	☐
Difficulty Swallowing	☐	☐
Bleeding Gums	☐	☐

Eyes:	Present	Past
Glaucoma	☐	☐
Double Vision	☐	☐
Blurred Vision	☐	☐

Respiratory:	Present	Past
Asthma	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐
Emphysema	☐	☐
Cold/Flu	☐	☐
Cough/Wheezing	☐	☐

Integumentary:	Present	Past
Skin Lesions	☐	☐
Skin Ulcers	☐	☐
Skin Disease	☐	☐
Eczema	☐	☐
Psoriasis	☐	☐

Allergic/Immunologic:	Present	Past
Hives	☐	☐
Immune Disorder	☐	☐
HIV/AIDS	☐	☐
Allergy Shots	☐	☐
Cortisone Use	☐	☐

Genitourinary:	Present	Past
Kidney Disease	☐	☐
Lower Side Pain	☐	☐
Burning Urination	☐	☐
Blood in Urine	☐	☐
Kidney Stone	☐	☐

Gastrointestinal:	Present	Past
Gallbladder Problems	☐	☐
Bowel Problems	☐	☐
Constipation	☐	☐
Liver Problems	☐	☐
Ulcers	☐	☐
Diarrhea	☐	☐
Nausea/Vomiting	☐	☐
Bloody Stools	☐	☐
Poor Appetite	☐	☐

Psychiatric:	Present	Past
Depression	☐	☐
Anxiety Disorder	☐	☐
Unusual Stress	☐	☐

Doctor's Initials

Past & Social History

Please mark all of the following that apply.

Medical Conditions:		Allergies:		Recreational Activites:	
Arthritis	☐	Seasonal Allergies	☐	Backpacking/Hiking	☐
Cancer	☐	Eggs	☐	Basketball	☐
Diabetes	☐	Fish and Shellfish	☐	Baseball	☐
Heart Disease	☐	Milk or Lactose	☐	Biking	☐
Hypertension	☐	Peanut	☐	Boating	☐
Psychiatric Illness	☐	Sulfites	☐	Dancing	☐
Skin Disorder	☐	Wheat/Gluten	☐	Football	☐
Stroke	☐			Golf	☐
Tumor	☐	**Occupational Activities:**		Racket Ball	☐
Other:	☐	Administration	☐	Running	☐
		Business Owner	☐	Skiing	☐
Surgeries:		Clerical/Secretarial	☐	Soccer	☐
Appendectomy	☐	Computer User	☐	Swimming	☐
Cardiovascular Procedure	☐	Construction	☐	Tennis	☐
Cervical Disc Procedure	☐	Daycare/Childcare	☐	Walking	☐
Hysterectomy	☐	Executive/Legal	☐	Weight Lifting	☐
Joint Replacement	☐	Food Service Industry	☐	Other:	☐
Laminectomies	☐	Healthcare	☐		
Lumbar Disc Procedure	☐	Heavy Equipment Operator	☐	**Social History:**	
Prostate Surgery	☐	Heavy Manual Labor	☐	Caffeine Use Occasionally	☐
Other:	☐	Home Services	☐	Caffeine Use Often	☐
		Household	☐	Chew Tobacco Occasionally	☐
Family History:	*Parent* *Sibling*	Light Manual Labor	☐	Chew Tobacco Often	☐
Arthritis	☐ ☐	Manufactoring	☐	Drink Alcohol Occasionally	☐
Cancer	☐ ☐	Medium Manual Labor	☐	Drink Alcohol Often	☐
Cholesterol	☐ ☐	Military	☐	Exercise Not At All	☐
Diabetes	☐ ☐	Police/Fire	☐	Exercise Occasionally	☐
Heart Problems	☐ ☐	Professional Services	☐	Exercise Often	☐
High Blood Pressure	☐ ☐	Retail Worker	☐	Experience Stress Occasionally	☐
Psychiatric	☐ ☐	Teacher	☐	Experience Stress Often	☐
Stroke	☐ ☐	Truck Driver	☐	Smoke Cigarettes Occasionally	☐
Thyroid	☐ ☐	Other:	☐	Smoke Cigarettes Often	☐

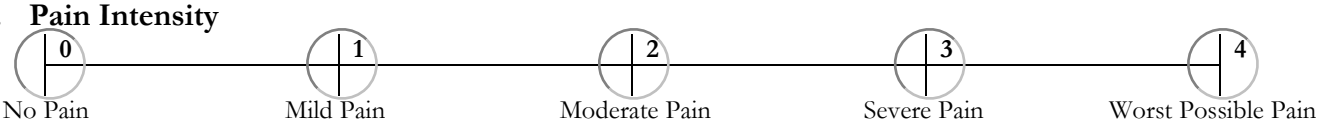
Additional Notes:_____

Doctor's Initials

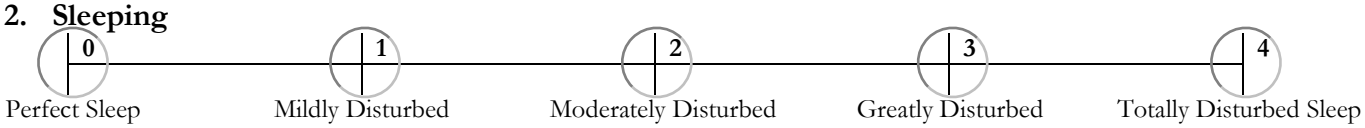
Functional Rating Index

For each item below, please circle the number, 0 – 4, which most closely describes your condition right now.

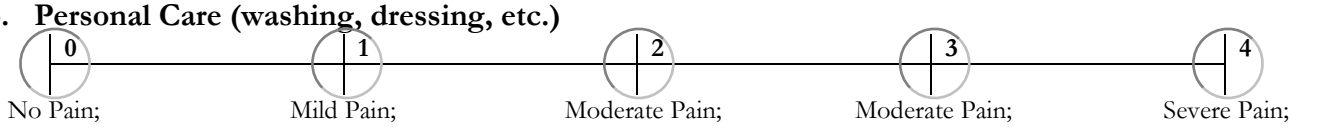
1. Pain Intensity



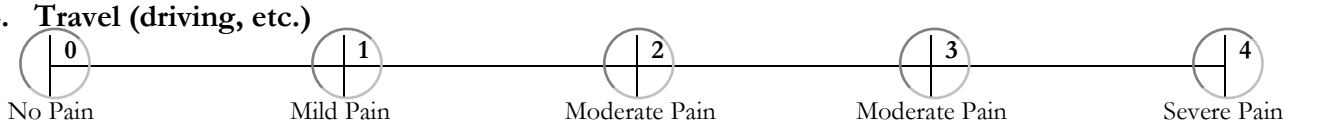
2. Sleeping



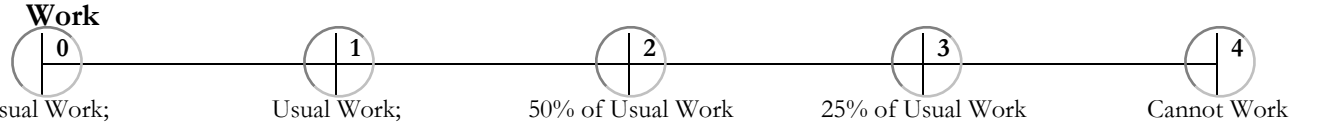
3. Personal Care (washing, dressing, etc.)



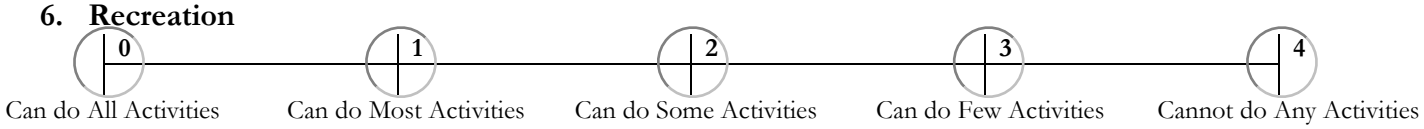
4. Travel (driving, etc.)



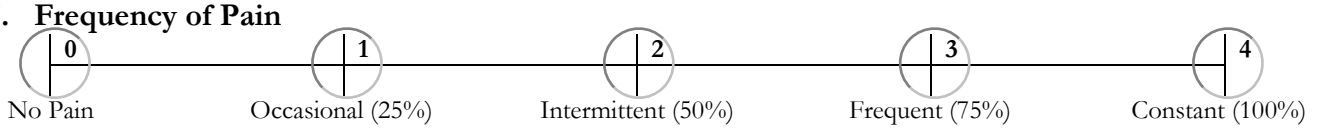
5. Work



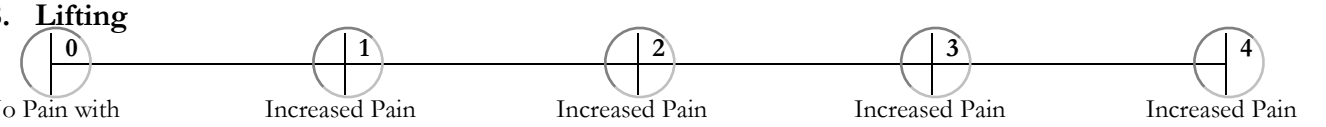
6. Recreation



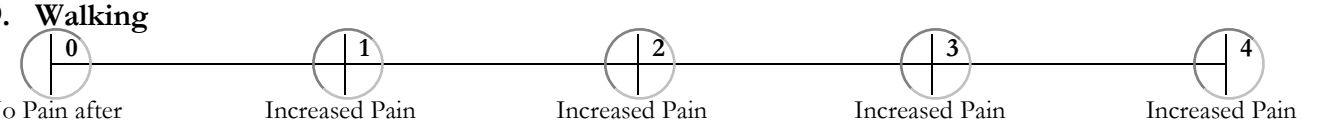
7. Frequency of Pain



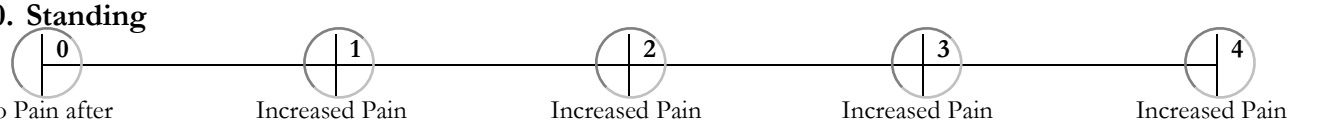
8. Lifting



9. Walking



10. Standing



Patient or Guardian Signature: X_____ Date: _____

Functional Rating Index Score: _____% (Completed by Dr. Swanson.)