Bozeman Chiropractic Clinic

Patient Information

Full Name: _____ Today's Date: _____ /_____ /_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____
(By providing my email address, I authorize Bozeman Chiropractic Clinic to contact me via email)

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text
May we contact you via text for appointment reminders? ☐ Yes ☐ No

Date of Birth: _____ /_____ /_____ Age: _____ SSN: _____

Gender: ☐ Male ☐ Female ☐ Unspecified Marital Status: ☐ Single ☐ Married ☐ Other

Emergency Contact: _____

Phone: _____ Relationship: _____

History of Present Injury, Illness, or Condition

Chief Complaint: _____

Are you experiencing (check any that apply): ☐ Pain ☐ Numbness ☐ Tingling ☐ Weakness

How did it originally occur? _____

_____

Date it began? (approx.) _____ /_____ /_____ Was it due to: ☐ Auto ☐ Work ☐ Other

Are the symptoms: ☐ Getting worse ☐ Getting better ☐ Staying the same

Are the symptoms: ☐ Constant ☐ Intermittent ☐ Worse at night ☐ Worse in the morning

Describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Cold ☐ Stabbing ☐ Penetrating

☐ Other _____

Does anything relieve the problem? ☐ Yes ☐ No If yes, please describe: _____

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Does anything make the problem worse? ☐ Standing ☐ Sitting ☐ Lying down ☐ Bending ☐ Other

_____

Have you ever had this same condition, or similar condition, in the past? ☐ Yes ☐ No

If yes, please describe: _____

Have you seen a chiropractor, or other doctor, for your current injury, illness, or condition? ☐ Yes ☐ No

If yes, what were the findings? _____

Was the treatment beneficial? ☐ Yes ☐ No ☐ Unsure

Have you ever had x-rays taken (other than dental x-rays)? ☐ Yes ☐ No ☐ Unsure

Are you pregnant or is there any possibility that you may be pregnant? ☐ Yes ☐ No ☐ Unsure

Past Medical History

Height and weight (please estimate if unknown): Height: _____ Weight: _____ lbs.

Do you have a history of high blood pressure? ☐ Yes ☐ No

Do you have a history of heart conditions? ☐ Yes ☐ No

If yes, do you have a pacemaker? ☐ Yes ☐ No

Do you have a history, or are you at risk, of stroke? ☐ Yes ☐ No

Have you ever been diagnosed with diabetes or pre-diabetes? ☐ Yes ☐ No

If yes, date you were diagnosed: _____ /_____ /_____ ☐ Type I ☐ Type II

Please describe any hospitalizations, surgeries, major illnesses, injuries, falls, or auto accidents: _____

_____

Current medications/remedies/vitamins/supplements (w/ dosage if known): _____

_____

_____

Do you have any known allergies? ☐ Yes ☐ No

If yes, please list any known allergies and your reaction(s): _____

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Have you ever been diagnosed as having, or suffered from, any of the following? (check all that apply):

General
☐ Fatigue
☐ Weakness
☐ Fever
☐ Chills
☐ Weight Change
☐ Night Sweats
☐ Difficulty Sleeping

Musculoskeletal
☐ Joint Pain
☐ Joint Stiffness
☐ Joint Swelling
☐ Joint Separation
☐ Sense of Instability
☐ Limping
☐ Pain Between the Shoulders
☐ Jaw, Ear, or TMJ Pain

Neurologic
☐ Numbness
☐ Tingling
☐ Paralysis
☐ Dizziness
☐ Nausea
☐ Fainting
☐ Headache
☐ Convulsions

Mental
☐ Anxiety
☐ Depression
☐ Inability to Focus
☐ Memory Impairment
☐ Confusion
☐ Phobias
☐ Mood Swings

Glandular
☐ Heat intolerance
☐ Cold intolerance
☐ Swelling of the neck
☐ Tremors
☐ Cramping

Cardiovascular
☐ Chest Pain
☐ Rapid Heartbeat
☐ Irregular Heartbeat
☐ High Cholesterol
☐ Vascular Disease
☐ Murmur
☐ Swollen Extremities
☐ Varicose Veins
☐ Pulsing in the Abdominal Area
☐ Easy Bruising

Lungs
☐ Difficulty Breathing
☐ Wheezing
☐ Coughing
☐ Blue Extremities
☐ Asthma

Skin
☐ Rash
☐ Redness
☐ Itching
☐ Hives
☐ Eczema
☐ Acne
☐ Skin Ulcers
☐ Hair Changes
☐ Nail Changes

Ears
☐ Hearing Loss
☐ Hearing Changes
☐ Ringing
☐ Itching
☐ Pain
☐ Discharge

Eyes
☐ Vision Changes
☐ Blurred Vision
☐ Double Vision
☐ Redness
☐ Pain

Nose
☐ Absence of Smell
☐ Unpleasant Smell
☐ Sinus Infection
☐ Pain

Mouth/Throat
☐ Absence of Taste
☐ Abnormal Taste
☐ Sore Throat
☐ Difficulty Swallowing
☐ Sores
☐ Bleeding

Gastrointestinal
☐ Abdominal Pain
☐ Abdominal Hernia
☐ Nausea/Vomiting
☐ Diarrhea
☐ Constipation
☐ Decreased Appetite
☐ Increased Appetite
☐ Excessive Thirst
☐ Black Stool
☐ Clay-Colored Stool
☐ Blood in the Stool

Urinary
☐ Unable to Urinate
☐ Unable to Hold Urine
☐ Frequent Urination
☐ Painful Urination
☐ Blood in the Urine
☐ Discolored Urine
☐ Flank Pain

Reproductive
☐ Changes in Sexual Activity
☐ Impotence
☐ Pain
☐ Abnormal Menstruation

Breasts
☐ Lumps
☐ Pain
☐ Dimpling
☐ Discharge

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Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week?_____

Do you use tobacco? ☐ Never ☐ Formerly ☐ Currently/Occasional ☐ Currently/Every Day

Do you use marijuana? ☐ Never ☐ Formerly ☐ Currently/Occasional ☐ Currently/Every Day

What do you do for exercise?_____

Number of times a week you exercise?_____ For how long each time? _____

Please describe your typical diet_____

_____

Estimated number of times/week you consume fast food ☐ Never ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ >4x

Family History

Please list any illness or condition (such as arthritis, fibromyalgia, eczema, migraines, genetic/congenital disorder(s), stroke, heart disease, high blood pressure, diabetes, cancer, etc.) that your biological parents or siblings may have been diagnosed with and/or suffered from

Father _____

Mother _____

Siblings _____

Thank you for your time completing this form. The information gathered is important for gaining a better understanding of your current health status.