COAST SPINE CENTER

**CHIROPRACTIC WELLNESS AND INJURY REHABILITATION**

# Confidential Patient Data

## PATIENT INFORMATION

Today's Date: _____

Name:_____ Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Phone 1-Home/Cell/Work:_____ Phone 2-(**Work**)_____

Social Security #:_____ Age:_____ ❑ Male ❑ Female

Marital Status: ❑Married ❑Single ❑Divorced ❑Separate ❑Widowed ❑Other

Spouse or Nearest Relative:_____ Phone:_____
Emergency Contact:_____ Phone:_____

Your Employer:_____ Your Occupation:_____

EMAIL ADDRESS:_____

❑ Health Insurance - Insurance Company:_____ ❑Cash ❑Check ❑LOP

❑ Auto Insurance- Insurance Company:_____ ❑Worker's Compensation
Claim Number:_____ Accident Date:_____

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# Please Describe Present Major Complaints

Date of Injury: _____

**1) Primary Complaint:** _____

Severity: 10 Being the Worst: 1 2 3 4 5 6 7 8 9 10 Frequency: (0-25%)(26-50%)(51-75%)(76-100%)

Aggravating Actions:_____

Relieving Actions:_____

Pain Radiates Into: _____

Quality of Pain: ❑Sharp ❑Dull ❑Achy ❑Burning ❑Other

Timing: ❑Morning ❑Afternoon ❑Evening ❑Constant ❑Comes/Goes

**2) Additional Complaint:** _____

Severity: 10 Being the Worst: 1 2 3 4 5 6 7 8 9 10 Frequency: (0-25%)(26-50%)(51-75%)(76-100%)

Aggravating Actions:_____

Relieving Actions:_____

Pain Radiates Into: _____

Quality of Pain: ❑Sharp ❑Dull ❑Achy ❑Burning ❑Other

Timing: ❑Morning ❑Afternoon ❑Evening ❑Constant ❑Comes/Goes

**3) Additional Complaint:** _____

Severity: 10 Being the Worst: 1 2 3 4 5 6 7 8 9 10 Frequency: (0-25%)(26-50%)(51-75%)(76-100%)

Aggravating Actions:_____

Relieving Actions:_____

Pain Radiates Into: _____

Quality of Pain: ❑Sharp ❑Dull ❑Achy ❑Burning ❑Other

Timing: ❑Morning ❑Afternoon ❑Evening ❑Constant ❑Comes/Goes

Additional:_____

Patient's Name:_____ Date:_____

**PLEASE MARK BELOW WHERE YOU HAVE BEEN SEEN FOR THIS CONDITION:**

❑ **I have not been seen yet for this condition.**

IF YES, CHECK AND NAME WHICH APPLY: ❑ER ❑Orthopaedic ❑Chiropractor ❑Physical Therapist

1) Name: _____ DATE:
❑ER ❑Orthopaedic ❑Chiropractor ❑Physical Therapist

2) Name: _____ DATE:
❑ER ❑Orthopaedic ❑Chiropractor ❑Physical Therapist

3) Name: _____ DATE:

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES PREFORMED FOR THIS INJURY?
❑YES ❑NO IF YES, PLEASE MARK BELOW.

| **Spinal X-rays** | **MRI** | **CT SCAN** |
|---|---|---|
| ❑Cervical | ❑Cervical | ❑Head |
| ❑Thoracic | ❑Thoracic | ❑Cervical |
| ❑Lumbar | ❑Lumbar | ❑Thoracic |
| ❑Other_____ | ❑Other_____ | ❑Lumbar |

DR/FACILITY WHO PERFORMED X-RAY:

DR/FACILITY WHO PERFORMED MRI:

DR/FACILITY WHO PERFORMED CT SCAN:

*Please check the following activities that **AGGRAVATE** your condition:*

| | | | |
|---|---|---|---|
| ❑SNEEZING | ❑ICE PACK | ❑HEAT PACK | ❑STRAINING / PRESSURE |
| ❑BENDING | ❑REACHING | ❑COUGHING | ❑**NONE OF THESE** |
| ❑SITTING | ❑TURNING HEAD | ❑LIFTING | |
| ❑WALKING | ❑LYING DOWN | ❑STANDING | |

*Please check the following activities that **RELIEVE** your condition:*

| | | | |
|---|---|---|---|
| ❑BENDING | ❑REACHING | ❑MEDICATION | ❑HEAT PACK |
| ❑SITTING | ❑TURNING HEAD | ❑LIFTING | ❑ICE PACK |
| ❑WALKING | ❑LYING DOWN | ❑STANDING | ❑**NONE OF THESE** |

Patient's Name:_____ Date:_____



ARE YOU **CURRENTLY** EXPERIENCEING ANY OF THESE SYMPTOMS BELOW?

REVIEW OF SYSTEMS: circle any known problems below:

| | | |
|---|---|---|
| Constitutional | Fevers – Chills – Weight Loss _____ | □ N/A |
| Eyes | Blindness – Blurriness – Cataracts _____ | □ N/A |
| Ears/Nose/Throat | Hearing Loss – Ringing – Nosebleeds _____ | □ N/A |
| Cardiovascular | Chest Pain – Tightness – Palpitations _____ | □ N/A |
| Respiratory | Cough – Wheezing – Shortness of Breath _____ | □ N/A |
| Gastrointestinal | Heartburn – Nausea – Reflux – Rectal Bleeding _____ | □ N/A |
| Genitourinary | Frequency – Urgency – Incontinence _____ | □ N/A |
| Musculoskeletal | Fractures – Arthritis – Joint Pain _____ | □ N/A |
| Skin | Itching – Lumps – Rashes – Blisters – Ulcers _____ | □ N/A |
| Neurological | Dizziness – Numbness – Tingling – Tremors _____ | □ N/A |
| Psychiatric | Nervousness – Depression – Memory Loss _____ | □ N/A |
| Endocrine | Excessive Thirst – Frequent Urination _____ | □ N/A |
| Lymphatic | Anemia – Bleeding – Transfusion _____ | □ N/A |
| Allergic/Immuno | HIV – Hepatitis _____ | □ N/A |

## PAST MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

Please indicate which conditions have been experienced by the above by marking appropriate boxes.
IF NONE APPLY PLEASE CHECK HERE: ❑N/A

| S | M | F | | S | M | F | | S | M | F | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | AIDS | ❑ | ❑ | ❑ | headaches | ❑ | ❑ | ❑ | sinus trouble |
| ❑ | ❑ | ❑ | anemia | ❑ | ❑ | ❑ | heart trouble | ❑ | ❑ | ❑ | serious injury |
| ❑ | ❑ | ❑ | arthritis | ❑ | ❑ | ❑ | high blood pressure | ❑ | ❑ | ❑ | tuberculosis |
| ❑ | ❑ | ❑ | asthma | ❑ | ❑ | ❑ | hepatitis | ❑ | ❑ | ❑ | rheumatism |
| ❑ | ❑ | ❑ | back pain | ❑ | ❑ | ❑ | HIV/ARC | ❑ | ❑ | ❑ | venereal disease |
| ❑ | ❑ | ❑ | bladder trouble | ❑ | ❑ | ❑ | kidney disorder | ❑ | ❑ | ❑ | neck pain |
| ❑ | ❑ | ❑ | bone fracture | ❑ | ❑ | ❑ | menstrual cramps | ❑ | ❑ | ❑ | scarlet fever |
| ❑ | ❑ | ❑ | bowel control loss | ❑ | ❑ | ❑ | multiple sclerosis | ❑ | ❑ | ❑ | rheumatic fever |
| ❑ | ❑ | ❑ | cancer | ❑ | ❑ | ❑ | muscular dystrophy | ❑ | ❑ | ❑ | epilepsy |
| ❑ | ❑ | ❑ | chest pain | ❑ | ❑ | ❑ | nervousness | ❑ | ❑ | ❑ | dislocated joints |
| ❑ | ❑ | ❑ | concussion | ❑ | ❑ | ❑ | numbness | ❑ | ❑ | ❑ | reproductive disorders |
| ❑ | ❑ | ❑ | convulsions | ❑ | ❑ | ❑ | polio | ❑ | ❑ | ❑ | indigestion |
| ❑ | ❑ | ❑ | diabetes | ❑ | ❑ | ❑ | poor circulation | ❑ | ❑ | ❑ | Other |

Please check if any of the following apply: □ N/A □Hemorrhage □Malignancy □Pacemaker □Infection □Pregnancy □Metal Implant

Explanation:_____

Patient's Name:_____ Date:_____

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## SOCIAL HISTORY

| | | | | |
|---|---|---|---|---|
| Tobacco usage | ❑None | ❑Light | ❑Moderate | ❑Heavy |
| Alcohol usage | ❑None | ❑Light | ❑Moderate | ❑Heavy |
| Drug usage | ❑None | ❑Light | ❑Moderate | ❑Heavy |
| Exercise | ❑Never | ❑Seldom | ❑Occasional | ❑Regularly |

## SURGICAL HISTORY: If this section does not apply to you please check here: ❑N/A

1_____ Date:_____
2._____ Date:_____

## ACCIDENT HISTORY (Please choose any that may have contributed to your current condition)

❑Job ❑Auto ❑Recreational ❑Other Date:_____

❑Job ❑Auto ❑Recreational ❑Other Date:_____

## FAMILY DOCTOR HISTORY

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Name of Family Dr ._____Doctor Contact Number:_____

Describe Condition: _____Date of Last Physical Exam: _____-_____-_____

Are you allergic to any medications? ❑NO ❑YES Please List:
1. _____2. _____3. _____

Are you taking any medications? ❑NO ❑YES Please List
1. _____2. _____3. _____

**THIS SECTION APPLIES TO WOMEN**

Are you pregnant? ❑NO ❑YES Is there a possibility you may be pregnant? ❑NO ❑YES

DATE OF LAST MENSTRUAL PERIOD:_____-_____-_____

**Patient Signature:_____ Date:_____**

Doctor Notes: _____

❑ Re: "Additional Symptoms"- patient was told to see their family M.D. If the following additional symptoms persist or worsen.

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