

Welcome To Aaragon Chiropractic

Patient Information

Date _____ SS# _____

Name _____
(Last)

(First) (M.I.)

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Status Married Single Widowed Divorced Separated

Number of Children _____ Ages _____

Occupation _____

Employer/School _____

Address _____

Spouse's Name _____

Spouse's Birthdate _____

Spouse's Employer _____

Primary Care Physician _____

Previous Chiropractor _____

Whom may we thank for referring you? _____

Financial Policy Agreement

I understand that with the exception of work-related injuries, I am ultimately responsible for the payment of the services rendered to me at Aaragon Chiropractic.

(Signature) _____

Insurance Provider _____

Are you taking medications?

Prescriptions: _____

Non-Prescription: _____

Vitamins/Minerals: _____

Daily Habits

Do you...

- Smoke _____ packs a day
- Drink Alcohol _____ drinks a day
- Drink Caffeine/Coffee _____ drinks a day

How is your...

- Stress Level: High Moderate Low None
- Work Activity: Sitting Standing Light Labor Heavy Labor
- Exercise Level: Heavy Daily Moderate None

Phone Numbers

Home _____ Work _____

Cell or other _____

Best time and place to reach you: _____

In case of emergency:

Name _____

Phone _____

Health History

Patient:

- Heart
- Diabetic
- High Blood Pressure
- Pacemaker
- Breast Implants
- Currently Pregnant

Family:

- Heart
- Diabetic
- High Blood Pressure
- Pacemaker

Patient Condition

Major complaint _____

Other complaints 1. _____ 2. _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No

Is it constant or bother 10% 30% 50% 70% of the time?

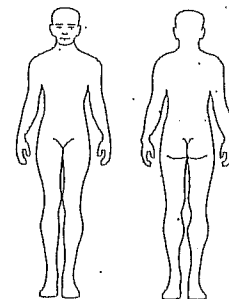
Rate the severity of your problem on a scale from 1 (least) to 10 (severe pain) _____

Type of symptoms: Sharp Dull Throbbing Numbness Aching

Shooting Burning Tingling Stiffness Other

Does it interfere with your: Work Sleep Daily Routine Recreation

Mark on the picture where you continue to have symptoms



P=Pain N=Numbness S=Spasm T=Tingling

Falls, Accidents/Injuries/Surgeries you had:	Descriptions	Dates
Falls	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Dates of previous car accidents: _____		

Please check your current symptoms:

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Cold Hands / Feet |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness in Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems to Heavy |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Fever | <input type="checkbox"/> Other _____ | |

Date of last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____ MRI / CT Scan _____

Personal Injury Questionnaire

Accident Information	How did you feel...
Date _____ Time of Day _____	During the accident: _____
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other _____	Immediately after the accident: _____
To whom have you made a report of your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Police <input type="checkbox"/> Other _____	_____
Name of supervisor _____	Later that day: _____
Have you retained an attorney? _____	The next day: _____

1. In your own words, please describe the accident: _____

2. Were you: Driver Passenger Front Seat Back Seat Aware of the accident

3. Number of people in your vehicle? _____ Were you wearing seat belts? _____ Type of vehicle _____

4. Were you struck from: Behind Front Left Side Right Side

5. Approximate speed of your car? _____ mph Other car? _____ mph Damage to your car? \$ _____

6. Were you: Unconscious Did you receive: Cuts Bruises Other _____

7. What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic None Other _____

8. Name and address of other doctor(s) or facilities (ER, AMPM, etc.) you have seen concerning this condition:

9. Have you lost time from work as a result of this accident? Yes No How Long? _____

10. Do you notice any activity restrictions as a result of this injury? Yes No

11 Is the pain worse when: Working Lifting Stooping Standing Sitting Bending Coughing Sleeping Walking

Other Information: _____

 (Signature) (Date)