

# ABOUT THE PATIENT

Pinnacle Chiropractic and Rehab, 3259 Oak Ridge Loop E., West Fargo, ND 58078

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Gender  M  F  
 Significant Other's Name \_\_\_\_\_ Kid's Names and Ages \_\_\_\_\_  
 Your Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
 e-Mail Address \_\_\_\_\_ Have you been to a chiropractor before?  No  Yes  
 Emergency Contact \_\_\_\_\_ ph # \_\_\_\_\_  
 Name of Medical Doctor(s)/Clinic \_\_\_\_\_

- I authorize the doctor or his/her staff to render care as deemed appropriate for me and / or my child.
- I authorize Pinnacle Chiropractic and Rehab to release and / or request records to or from other providers as may be necessary.
- In order to ensure that all of my healthcare providers function as a team, I hereby give my consent to the providers and clinical staff at Pinnacle Chiropractic to communicate with and relay any information about my condition to my other healthcare providers.
- I understand I am responsible for all bills incurred in this office.
- Person responsible for this account if other than the patient? \_\_\_\_\_

\_\_\_\_\_  
 Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date \_\_\_\_\_

## REASON FOR SEEKING CARE

### PRESENT COMPLAINTS

- \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_
- \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_
- \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_
- \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

5. Does your condition affect:  Sleep  Work  Daily Routine  Sitting  Driving

6. What makes it better? \_\_\_\_\_

7. What makes it worse? \_\_\_\_\_

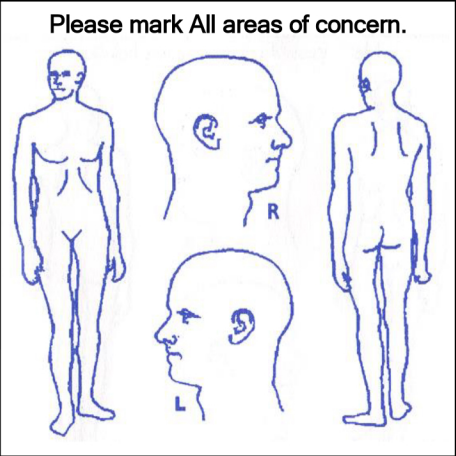
8. What Doctor's have you seen for this? \_\_\_\_\_

9. Type of treatment: \_\_\_\_\_

10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Are you pregnant?**  
 Yes  No



# GENERAL HEALTH HISTORY

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Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

Past Present

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle Aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Urinary Problems
- Other \_\_\_\_\_

Past Present

- Recent Weight Loss
- Night Sweats
- Blood in the Urine
- TMJ
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Tension / Irritability
- \_\_\_High or \_\_\_Low Blood Pressure
- Stroke History
- High Cholesterol
- Easy Bruising
- Digestive Problems
- Pain all Over
- Chest Pains
- Heart Pacemaker
- Heart Problems
- Alcohol Use
- Tobacco Use

1. List any medications you are taking: \_\_\_\_\_

2. Please list all doctors you are currently seeing: \_\_\_\_\_

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

4. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_

5. List any past work injuries: \_\_\_\_\_ Was any care received? \_\_\_\_\_

6. List any past sport, recreational, or home injuries \_\_\_\_\_

7. Please describe any past conditions and treatment received: \_\_\_\_\_

8. Please list any past hospitalizations and surgeries: \_\_\_\_\_

## FAMILY HISTORY

Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

Is there any other family history you want us to know? \_\_\_\_\_