# Iowa Chiropractic Center

725 Blairs Ferry Rd | Marion, IA | 52302 | (319) 393-3998

## 1. Patient Information

**Today's Date**: _____

**Name**: _____ _____
First Last (Nickname)

**Mobile Phone**: ( ____ ) _____ - _____

**Email**: _____

**Street Address**: _____

**City/State/Zip**: _____

**Date of Birth**: _____ **Age**: _____

**Sex**: ☐ Male ☐ Female

**Occupation**: _____

**How did you hear about our office?**

- ☐ Google/Internet search
- ☐ Social Media _____ (Facebook, Instagram, Twitter, etc.)
- ☐ Advertisement _____ (Internet, Newspaper, Radio, etc.)
- ☐ Referral from _____ (Patient name, Doctor, PT, etc.)
- ☐ Other _____

## In Case of Emergency, Please Contact:

**Name**: _____ _____
First Last Relation to Patient

**Mobile Phone**: ( ____ ) _____ - _____

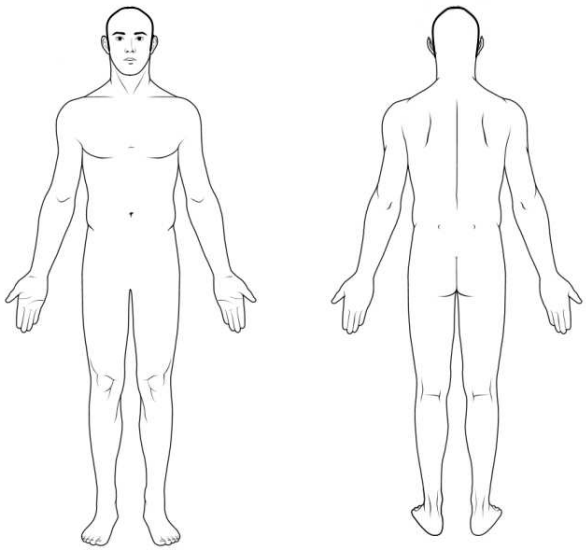
**Work Phone**: ( ____ ) _____ - _____

## 2. Pain Diagram

Place an "**X**" on the diagram to indicate your area(s) of complaint:

**FRONT** **BACK**

**Right** **Left** **Left** **Right**



**-----** Please proceed to page 2 unless your ----- condition is due to an accident****

## Accident Information

*Complete ONLY if your condition is due to an accident*

Type of accident: ☐ Auto ☐Work ☐Other _____

Date of accident: _____

To whom have you made a report of your accident?

☐Auto Insurance ☐ Employer ☐ Worker's Comp
☐ Other _____

Claim number (if applicable): _____

Attorney's Name (if applicable): _____

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## 3. History

**Main reason for seeking chiropractic care today:**

_____

_____

**Location of your pain/complaint:**

_____

**When and how did this begin?**

When: _____

How: _____

**Frequency of pain/complaint**:

Constant Intermittent Situational

**Quality of pain:**

Dull Aching Sharp Shooting Burning Throbbing

Deep Stiffness Numb/Tingling Other _____

**Does the pain radiate or travel to other areas of your body?** Yes No

If yes, where: _____

**Rate the intensity of your pain at rest and with activity**:

**0** = none present, **10** = hospitalization needed

**At Rest:**

0 1 2 3 4 5 6 7 8 9 10

**With Activity:**

0 1 2 3 4 5 6 7 8 9 10

**Does anything make your complaint worse?**

_____

**Does anything make your complaint better?**

_____

**Have you had this complaint before?**

Yes No

**Have you seen any other healthcare professional for this complaint?** Yes No

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**Have you ever received chiropractic care?** Yes No

If yes, when was your last visit? _____

**Have you had any x-rays or other medical imaging done in the past year?** Yes No

****Female patients only****

**Are you now or could you be pregnant?** Yes No

**Date of last menstruation**: _____

**(Please continue on to the next page)**

## Doctor's Notes:

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## 4. Nutrition & Exercise: Nutrition and exercise are **important aspects of healing**. Give your best estimates below:

1. On average, how many **days do you exercise** per week?

   0 days  1-3 days  3-5 days  5-7 days

2. What **type of exercise** do you typically participate in? (circle all that apply)

   Walking  Running  Weightlifting  Dance

   CrossFit  Swimming  Other _____

3. How many **hours of sleep** do you get per night?

   5 or less  6-7 hrs.  8 or more

4. How many **cups of water** do you consume in one day?

   0  1-2  3-4  5-7  8+

5. How many **meals** do you consume in one day?

   1  2  3  4  5+

## 5. Social History: Check one answer for each section.

**Smoking:**

- ☐ Smoker
- ☐ Non-smoker
- ☐ Other _____

**Alcohol:**

- ☐ Everyday drinker
- ☐ Occasional drinker
- ☐ Former drinker
- ☐ Never drink

**Sexually active:**

- ☐ Yes
- ☐ No

****** USE THE BACK OF THIS PACKET IF YOU NEED EXTRA SPACE FOR THE FOLLOWING SECTIONS ******

## 6. Allergies: List all **medication**, **food**, **pet**, or **any other allergies** you have using the space below.

_____

_____

## 7. Family History: List all past and present **health conditions** in your family (i.e. cancer, diseases, severe illnesses, etc.)

Mother: _____  Siblings: _____

Father: _____  Grandparents: _____

## 8. Medications/Supplements: Provide a list of your **current medications** to the front desk staff or list them below.

| | Name of medication/supplement | Dosage (in mg) | Frequency (1x/day, AM/PM, etc.) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

## 9. Hospitalizations/Surgeries: List all **past surgeries or hospital visits** you have had.

| Date | Type of Surgery/Reason for Hospital visit |
|---|---|
| 1. | |
| 2. | |

## 10. Injury History: List all past injuries or major events (i.e. car accidents, fractures, torn ligaments, major falls, etc.)

| Year/Date | Type of Accident/Injury |
|---|---|
| 1. | |
| 2. | |

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## 11. Review of Systems: Check the boxes for all conditions you have experienced or are currently experiencing:

**Eyes/Ears/Nose/Throat:**
- ☐ Headaches
- ☐ Visual Problems
- ☐ Dizziness/Fainting
- ☐ Seizure
- ☐ Stroke
- ☐ Ear Infections/Troubles
- ☐ Hearing loss
- ☐ Sinus congestion
- ☐ Allergies
- ☐ Hoarseness
- ☐ Trouble swallowing
- ☐ Other: _____
- ☐ **None of the above**

**Heart:**
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Palpitations/irregular beat
- ☐ Chest pain/angina
- ☐ Enlarged heart
- ☐ Abnormal EKG
- ☐ Rheumatic fever
- ☐ Tire easily
- ☐ Frequent ankle swelling
- ☐ Anemia
- ☐ Blood disorder
- ☐ Other: _____
- ☐ **None of the above**

**Bones/Joints/Muscles:**
- ☐ Arthritis
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Varicose veins
- ☐ Blood clots/phlebitis
- ☐ Bursitis
- ☐ Other: _____
- ☐ **None of the above**

**Lungs/Pulmonary:**
- ☐ Cough
- ☐ Asthma
- ☐ Wheezing/Shortness of breath
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Night sweats
- ☐ Chest pain
- ☐ Coughed up blood
- ☐ Tuberculosis
- ☐ Pleurisy
- ☐ Other: _____
- ☐ **None of the above**

**Kidney/Urology:**
- ☐ Kidney disease/infection
- ☐ Bladder infection
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Prostate troubles
- ☐ Impotence
- ☐ Infertility
- ☐ Sexual difficulties
- ☐ Sexually transmitted diseases
- ☐ Other: _____
- ☐ **None of the above**

**Stomach/GI tract:**
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Ulcers
- ☐ Vomiting blood
- ☐ Bloody or dark stool
- ☐ Abdominal pain
- ☐ Colitis
- ☐ Gall bladder trouble
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Other: _____
- ☐ **None of the above**

**Endocrine/Hormone:**
- ☐ Diabetes
- ☐ Thyroid trouble
- ☐ Abnormal cholesterol
- ☐ Weakness/fatigue
- ☐ Sudden weight gain or loss
- ☐ Trouble sleeping
- ☐ Hypoglycemia
- ☐ Hot flashes
- ☐ Goiter
- ☐ Breast pain
- ☐ Breast lumps/abnormality
- ☐ Testosterone imbalance
- ☐ Estrogen imbalance
- ☐ Other: _____
- ☐ **None of the above**

**Emotional/Psychological:**
- ☐ Emotional illness
- ☐ Excessive worry/anxiety
- ☐ Panic attacks
- ☐ Change in appetite
- ☐ Mood Swings
- ☐ Feelings of worthlessness
- ☐ Feelings of hopelessness
- ☐ Constant unhappiness
- ☐ Difficulty sleeping
- ☐ Other: _____
- ☐ **None of the above**

**Skin:**
- ☐ Change in moles or warts
- ☐ Itching/Rash/Hives
- ☐ Acne
- ☐ Tumor/new growth
- ☐ Skin Cancer
- ☐ Swelling
- ☐ Other: _____
- ☐ **None of the above**