Patient Information

Date _____

Patient Name (Last Name) _____

(First Name)_____

(Middle Initial)_____

Email_____

Address_____

City _____

State Zip _____

Sex M F Age_____

Birth Date _____

□Married □Single □Divorced

□Domestic Partner

Phone Numbers

Cell Phone _____

Home Phone _____

Best time and place to reach you

_____

In Case of Emergency, Contact

Name _____

Relationship_____

Home Phone _____

Cell Phone _____

Health Insurance Provider:

_____

Patient Employer/School_____

_____

Occupation _____

Who may we thank for referring you?

Range of Motion Chiropractic

2850 Artesia Blvd. Ste.201
Redondo Beach, CA
90278
310.978.7807
info@romchiro.com
www.romchiro.com

Patient Condition

Chief Complaint_____

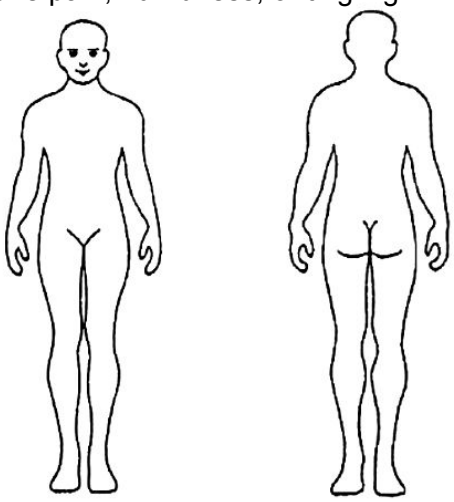
When did your symptoms appear?

_____

Is this condition getting progressively worse?

□Yes □No □Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



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

Type of pain: □Sharp □Dull
□Throbbing □Numbness
□Aching □Shooting □Burning
□Tingling □Cramps □Stiffness
□Swelling □Other_____

How often do you have this pain?

_____

Is it constant or does it come and go?

_____

Does it interfere with your:

□Work □Sleep □Daily Routine

□Recreation □NA

Activities or movements that are painful to perform:

□Sitting □Standing □Walking □Bending
□Lying Down □NA

Health Information

What treatment have you already received for your condition? □Medications □Surgery

□Physical Therapy □Chiropractic Services □None □Other

Name and address of other doctor(s) who have treated you for your condition:

_____

_____

Date of Last: Physical Exam_____ Spinal X-ray_____

Blood Test_____ Spinal Exam_____

Chest X-ray_____ Urine Test_____

Dental X-ray_____ MRI, CT-Scan, Bone Scan_____

Place a circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes No	Chicken Pox	Yes No	Kidney Disease	Yes No	Rheumatoid Arthritis	Yes No
Alcoholism	Yes No	Corticosteroid	Yes No	Liver Disease	Yes No	Rheumatic Fever	Yes No
Allergy Shots	Yes No	Diabetes	Yes No	Measles	Yes No	Scarlet Fever	Yes No
Anemia	Yes No	Emphysema	Yes No	Migraines	Yes No	Stroke	Yes No
Anorexia	Yes No	Epilepsy	Yes No	Miscarriage	Yes No	Suicide Attempt	Yes No
Appendicitis	Yes No	Fatigue	Yes No	Mononucleosis	Yes No	Thyroid Problem	Yes No
Arthritis	Yes No	Fractures	Yes No	MS	Yes No	Tonsilitis	Yes No
Asthma	Yes No	Glaucoma	Yes No	Mumps	Yes No	Tuberculosis	Yes No
Birth Control Pills	Yes No	Goiter	Yes No	Osteoporosis	Yes No	Tumors, Growths	Yes No
Bleeding Disorder	Yes No	Gonorrhea	Yes No	Pacemaker	Yes No	Thyphoid Fever	Yes No
Breast Lumps	Yes No	Gout	Yes No	Parkinson's	Yes No	Ulcers	Yes No
Bronchitis	Yes No	Headaches	Yes No	Pinched Nerve	Yes No	Vaginal Infections	Yes No
Bulimia	Yes No	Heart Disease	Yes No	Pneumonia	Yes No	Venereal Disease	Yes No
Cancer	Yes No	Hepatitis	Yes No	Polio	Yes No	Whooping Cough	Yes No
High Cholesterol	Yes No	Hernia	Yes No	Prostate Problems	Yes No	Other:_____	
Chemical. Dep.	Yes No	Herniated Disc	Yes No	Psychiatric Care	Yes No		
Chest Discomfort	Yes No	Herpes	Yes No	Rapid Heartbeats	Yes No		

Are you pregnant? □Yes □No Due Date_____

Please list all Injuries/Surgeries you have had: Description Date

Falls _____ _____

Head Injuries _____ _____

Broken Bones _____ _____

Dislocations _____ _____

Surgeries _____ _____

Lifestyle

Exercise
□ None
□ Moderate
□ Daily
□ Heavy

Work Activity
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits
□ Smoking
□ Alcohol
□ Coffee/Caffeine Drinks
□ High Stress Level

Medications
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Allergies
1) _____
2) _____
3) _____
4) _____

How often do they occur?

_____

Vitamins/Supplements
1) _____
2) _____
3) _____
4) _____

□ Daily □ Weekly □ Occasionally

If more space is needed, please use the back of this page.

Is there any additional information you feel as if you need to express that has not been covered in this patient intake form? _____

_____

_____

The statements made as to the questions asked on this form are accurate to the best of my knowledge, and I agree to allow this office to examine me for further evaluation. I understand that any and all information on this form and in this file will remain confidential to myself, the doctor, and any other authorized personnel.

X_____
Patient/Legal Guardian Signature

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