Welcome to our office...

GET-ACQUAINTED CARD

Patient's Name _____ Date of Birth ____/____/____

Name of Parents (If Child) _____

Full Name of Spouse _____

Residence Address _____

City & State _____ Zip _____ Phone _____

Head of Household Employed by _____ Occupation _____

Business Address _____ Bus. Phone _____

Spouse or Parent Employed by _____ Occupation _____

Business Address _____ Bus. Phone _____

Insurance Coverage (please give name and address of company, Medicare, welfare, etc. and necessary numbers)

Social Security No. _____

Referred by _____

Date of Last Physical Exam. _____ Reason _____

Cell Number _____

(USE OTHER SIDE IF MORE ROOM IS NEEDED)

#18134 — Medical Arts Press 1-800-328-2179

Lafayette Hilltop Chiropractic Center

Patient's Name: _____ **Birth Date**_____ **Date:**_____

What Is Your Current Complaint:_____

_____

_____

Date of Onset: _____

Location: _____ **Severity**_____
Where is the problem **scale of 1-10 with 10 being the most severe**

What Caused Your Problem: **accident, injury or no specific reason**_____

_____

How Would You Describe Your Pain: circle all that apply;
Sharp Soreness Throbbing Tingling Dull Stiffness
Spasm Burning Numbness Weakness Ache Shooting

How Often Is It Present:
Constant (81-100%) ☐ **Frequent (51-80%)** ☐

Occasional (26-50%) ☐ **Intermittent (25% or less)** ☐

What Makes It Better: circle all that apply
Nothing Walking Standing Sitting Moving/Exercise Lying down Inactivity

What Makes It Worse: circle all that apply
Nothing Walking Standing Sitting Moving/Exercise Lying down Inactivity

Were You Previously Treated For this Condition: Yes No
If yes, by whom? MD Chiropractor Physical Therapist Other

Present Medical Doctors	**Medications/Vitamins**
_____	_____
_____	_____
_____	_____

Have You Ever Been Hospitalized:
List dates and reasons
_____
_____
_____

Have You Ever Had Surgery:
list dates and type of surgery
_____
_____
_____

Have You ever been involved in a motor vehichle accident: Yes No
Describe how the accident occurred_____
_____
_____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Past or Present Symptoms, Conditions, or Habits

Below is a list of symptoms, conditions, or habits. Please check all that apply

Symptom	Past	Present	Symptom	Past	Present
Neck Pain	☐	☐	High Blood Pressure	☐	☐
Shoulder Pain	☐	☐	Heart Condition	☐	☐
Arm/elbow Pain	☐	☐	Respiratory Condition	☐	☐
Hand Pain	☐	☐	Digestive Problem	☐	☐
Upper Back Pain	☐	☐	Kidneys/Bladder Problems	☐	☐
Lower Back Pain	☐	☐	Menstrual Problems	☐	☐
Upper Leg or Hip Pain	☐	☐	Breast Soreness/lump	☐	☐
Lower Leg or Knee Pain	☐	☐	Sinus Condition	☐	☐
Ankle or Foot Pain	☐	☐	Allergies/Asthma	☐	☐
Jaw Pain	☐	☐	Cancer	☐	☐
Swelling/stiffness of joints	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Excessive weight loss or gain	☐	☐
Dizziness	☐	☐	Skin Condition	☐	☐
Fainting Spells	☐	☐	Arthritis	☐	☐
Convulsions	☐	☐	Diabetes	☐	☐
General prolonged fatigue	☐	☐	Prostate	☐	☐
Condition of Uterus/Ovaries	☐	☐			

Tobacco Use:
☐Past ☐Present ☐Occasional
☐Moderate ☐Heavy

Alcohol Use:
☐Past ☐Present ☐Occasional
☐Moderate ☐Heavy

Caffeine Use: (coffee, tea, soft drinks)
☐Past ☐Present ☐Occasional
☐Moderate ☐Heavy

Pregnancy:
☐ Past ☐ Present

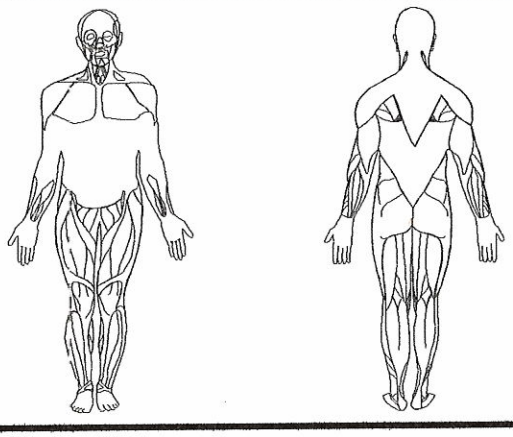
Birth Control Pills: Yes No

Comments: _____

_____

_____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date