Southern Oregon Spine+Rehab

Welcome to our family.

Patient Demographic Information:

Legal Name ____
Last *First* *Middle*

Preferred Name ____

*DOB*_____________________ *Age* ___________

SSN ____________________ *Height* _____ft. _____in. *Weight*________ lbs

Today's Date: _____________*Email:*____________________________

Would you be interested in receiving our monthly email newsletter? We will not spam or sell your information (Please circle) **Yes** **No**

*Gender:*_____________________

Address: ____

City:_____________________ *State:*_______ *Zip:*___________

Cell Phone Number ____________ *Home Phone Number* ______________

Do we have permission to leave you a detailed voicemail? **Yes** **No**

Who can we thank for referring you to our office? ______________________

(Please circle one):

Married **Single** **Divorced** **Separated** **Widowed** **Other**

Who are we authorized to speak with regarding your healthcare information? *(optional)*

*Name:*_____________________ *Relationship*:_______________

Who can we contact in case of emergency? ______________________

Relationship:_______________ *Phone Number*:_______________

Patient Employer Information (if applicable):

Employer: ____

Occupation:____

Southern Oregon
Spine+Rehab

Welcome to our family.

Personal Health History:

Name of Primary Care Provider: ______________________________

Have you had previous chiropractic care? **Yes** **No**

Are you currently pregnant or planning to be? **Yes** **No**

Please list all medication (including over the counter) currently taken: (Or provide list)

____

Please list all supplements, vitamins, or herbs currently taken: (Or provide list)

____

Allergies: ____

Previous Fractures (and dates):____

Major Sprains/Strains/Falls (and dates): ____________________________________

Previous Surgery (and dates): ____

Previous Cancer Diagnoses (and dates):_____________________________________

Have you ever had a stroke? **Yes** **No**

Have you ever been struck unconscious? **Yes** **No**

Do you consume alcoholic beverages? **Yes** **No** **# of drinks ________ / Week**

Do you consume caffeine? **Yes** **No** **#of drinks __________ /Day**

Do you use tobacco products? **Yes** **No** **#cans or packs ________ / Day**

Do you use recreational drugs? **Yes** **No** **Please specify ______________________**

Do you exercise? **Yes** **No** **times per week ________**

- Type of exercise ____

Southern Oregon Spine+Rehab

Welcome to our family.

Health Problems + Concerns

(Please circle all that apply to your current or past health history)

Allergies
Alcoholism
Anemia
Arteriosclerosis
Arthritis
Asthma
Autoimmune Disease
Back Pain
Bleeding Disorders
Breast Lump
Bronchitis
Bruise Easily
Cancer
Cataracts
Chest Pain
Cold Extremities
Constipation
COPD/Emphysema
Cramps
CVA/Stroke/TIA
Dementia/Alzheimer's
Depression/Anxiety
Diabetes
Digestive Problems
Dizziness
Epilepsy
Excessive Menstruation
Eye Pain or difficulties
Fatigue
Frequent Urination
Gallbladder Disease/Stones
Glaucoma
Gout
Headache
Heart Disease
Hemorrhoids
Hot Flashes
High Blood Pressure
High Cholesterol
Irregular Heart Beat
Irregular Menstrual Cycle
Kidney Infections
Kidney Stones
Liver Disease
Loss of Memory
Loss of Balance
Loss of Smell
Loss of Taste
Lung Disease
Macular Degeneration
Mental or Emotional Health Disorders
Migraines
Nosebleeds
Pacemaker
Parkinson's
Polio
Prostate Trouble
Retinal Disease
Sciatica
Seizures
Shortness of Breath
Sinus Infection
Sleep Problems/Sleep Apnea/Insomnia
Skin Sensitivity
Smoker Previous or Current
Spinal Curvatures/Scoliosis
Swelling of Ankles
Swollen Joints
Tourette's Syndrome
Thyroid Condition
Tuberculosis
Ulcers
Varicose Veins

Other ______________________________

Southern Oregon
Spine+Rehab

Welcome to our family.

Family Health History:

Have any family members been diagnosed with these health conditions:

Arthritis **Cancer** **High Blood Pressure** **Kidney Disease**

High Cholesterol **Stroke** **Heart Attack** **Autoimmune Diseases**

Neurological Diseases **Diabetes** **Scoliosis** **Other** ________________

Current Condition:

Reason for today's visit: ____

How long have you had this condition? ____

Is this condition due to a motor vehicle collision? **Yes** **No**
Is this condition due to a work related injury? **Yes** **No**

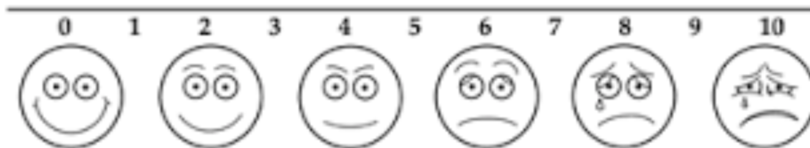
Have you had imaging (X-ray, MRI, etc.) of this complaint? **Yes** **No**

If so, where?_____________________________

In your arms or legs, do you have?: (Please circle all that apply)

Radiating Pain **Numbness** **Tingling** **Weakness**

Please rate your pain 0-10 (0 = no pain, and 10= worst pain imaginable)



Type of pain: (Please circle all that apply)

Dull **Aching** **Sharp** **Tightness/Stiffness** **Shooting** **Burning**

Tingling **Other** ____

How often do you have this pain? (Please circle) **Constant** **Comes and goes**

What makes your pain worse? (Please circle)

Bending **Twisting** **Lifting** **Sitting** **Standing** **Laying** **Walking**

Working **Chores** **Driving** **Turning** **Exercising** **Getting out of bed**

Other ____

Southern Oregon
Spine+Rehab

Welcome to our family.

What makes your pain better? (Please circle)

Rest Sitting Standing Walking Sleep Exercise Medicine Laying

Chiropractic Massage Acupuncture Redirected attention

Other ____

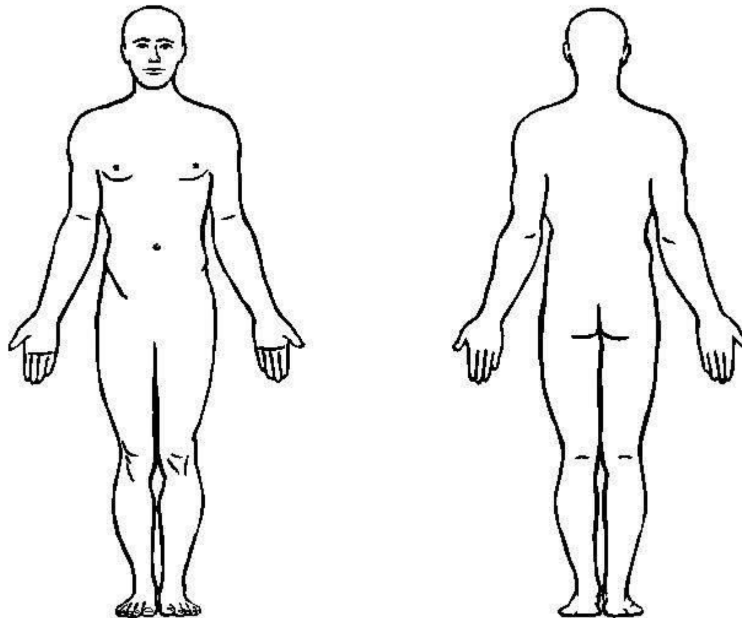
What other treatments have you tried? (Please circle)

Prescription medication Over-the-counter medication Physical therapy

Massage Chiropractic Acupuncture Injections Surgery

Mental Health Services Other ______________________________

Please mark on the body chart where you are experiencing pain.



I attest the above listed information is accurate to the best of my knowledge.

Signature:______________________________ Date:_______________