Akridge & Akridge
CHIROPRACTIC

Physician Signature:_____

Patient Name:_____ Today's Date:_____

D.O.B:_____ S.S #_____-___-_____ Sex: M F Marital Status: Single Married Divorced Widowed

Address:_____ City:_____ State:___ Zip:_____

Cell Phone:_____ Home Phone:_____

E-Mail:_____

Place of Employment:_____ Occupation:_____

How were you referred to our office:_____

Review of Systems: Mark (c) for current problems, check and indicate age when you had any of the following:

General:

- ☐ Depression
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Tremors
- ☐ Weight Loss/Gain
- ☐ Alcoholism
- ☐ Appendicitis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Numbness/Tingling
- ☐ Osteoporosis

Muscle Joint:

- ☐ Arthritis/Rheumatism
- ☐ Bursitis
- ☐ Muscle Weakness
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Joint Pain

Gastrointestinal/Genitourinary:

- ☐ Abdominal Pain
- ☐ Bloody or Tarry Stool
- ☐ Colitis/Crohn's
- ☐ Constipation
- ☐ Gallbladder Trouble
- ☐ Hernia
- ☐ Bed-Wetting
- ☐ Bladder Infection
- ☐ Kidney Problems

Cardiovascular/Respiratory:

- ☐ High/Low Blood Pressure
- ☐ Pain over heart
- ☐ Swelling of Ankles
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Stroke

Women Only:

Menstrual Flow:

Reg. Irreg. Pain/Cramps

Date – 1st day of last Period:_____

Are You Pregnant? Yes, No

If yes, How many months?_____

How many children do you have?_____

Birth control Method:_____

Past Health History:

Have you…

Been hospitalized in the last 5 years **Yes No Explain:**_____

Had any broken bones **Yes No Explain:**_____

Had any strains or Sprains **Yes No Explain:**_____

How is most of your day spent? **Standing Sitting Other:**_____

How old is your mattress? _____

When was your last physical exam? _____

Habits:

Alcohol:	None	Light	Moderate	Heavy
Tobacco:	None	Light	Moderate	Heavy
Drugs:	None	Light	Moderate	Heavy
Exercise:	None	Light	Moderate	Heavy
Sleep:	None	Light	Moderate	Heavy
Soft Drinks/Caffeine:	None	Light	Moderate	Heavy
Salty Foods:	None	Light	Moderate	Heavy
Water:	None	Light	Moderate	Heavy

Do you have any other health issues or concerns that our staff should be aware of? _____

_____

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Family History: **If any blood relative has had any of the following conditions, please check and indicate which relative(s)**

☐ **Alcoholism**	☐ **Cancer**	☐ **High blood pressure**
☐ **Anemia**	☐ **Diabetes**	☐ **High Cholesterol**
☐ **Arteriosclerosis**	☐ **Emphysema**	☐ **Multiple Sclerosis**
☐ **Arthritis**	☐ **Epilepsy**	☐ **Osteoporosis**
☐ **Asthma**	☐ **Heart Disease**	☐ **Stroke**

Patient Medication List: Please list clearly all medications and supplements and why you are taking them.

_____

_____

Patient Current Complaint:

Give a brief description of the problem you are currently experiencing: _____

_____

_____

_____

How long have you had this condition:_____ **Is it getting worse? YES NO**

What seems to be the initial cause: _____

What makes your pain worse? _____

What makes your pain better? _____

Describe the type of pain you are having, Dull, Sharp, Shooting, etc.:_____

What activities are your complaints interfering with? _____

What do you hope to achieve with receiving care in our office? _____

_____