1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_____

Employer_____

Number of Children: _____

Email: _____

Spouse's Name: _____

Birthdate_____

Occupation_____

Whom may we thank for referring you?_____

_____

2 PROCEDURES

*I authorize Geraldine Greenberg,D.C.,LAc. to render professional care to me.

*24hrs notice requested to avoid missed appt fee.

*Fees are due when services have been rendered.

*I give Dr. Greenberg's office permission to send educational material to me .

*This is notice of privacy procedures Greenberg Chiropractic/Acupuncture Office has adopted to protect the privacy of your health information & that we have modified our security procedures.

_____

Patients signature Date

3 PHONE NUMBERS

Home_____

Work_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)_____

5 PATIENT CONDITION

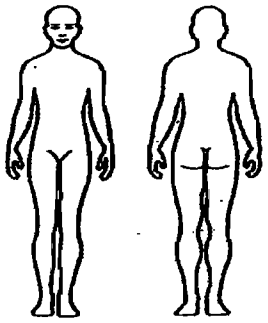
HEIGHT ____'/____" WEIGHT _____ Lbs.

Reason for Visit_____

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

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

____Pain in the AM / with stiffness____ Pain at nite ____Pain unrelieved by rest/position

What treatment have you received for this condition?_____

Have you had spinal X -RAYS, MRI, CT scans _____NO _____Yes _____approx date

6 HEALTH HISTORY

PAST (O) OR PRESENT (X) CONDITIONS:

A
- _____ Fractured Bones
- _____ Auto Accidents
  - (a) _____ 0-1 years ago
  - (b) _____ 1-5 years ago
  - (c) _____ More than 5 years ago
- _____ Other Accidents/Falls
- _____ Knocked Unconscious
- _____ Back Curvature
- _____ Mental or Emotional Disorders
- _____ Arthritis
- _____ Diabetes
- _____ Swollen or Painful Joints
- _____ Convulsions/Epilepsy
- _____ Skin Problems
- _____ Itching
- _____ Bruise easily
- _____ Cancer
- _____ Frequent Colds/Flus

B
- _____ Nervous
- _____ Tension
- _____ Depressed
- _____ Irritable
- _____ Anemia
- _____ Excess Sweating
- _____ Tremors
- _____ Light bothers eyes
- _____ Allergy
- _____ Sinus Problems
- _____ Light headed upon arising
- _____ Under stress
- _____ Crave sweets or salt
- _____ Eating disorders

C
- _____ Trouble sleeping
- _____ Trouble concentrating
- _____ Loss of memory
- _____ Learning Disability
- _____ Mistake sidedness (R. from L)
- _____ Stutter
- _____ Dyslexia
- _____ Mood Changes
- _____ Lose Temper easily

D
- _____ Headache
- _____ Neck pain or stiff R. L.
- _____ Numbness, tingling or pain in arms, hands, fingers R. L.
- _____ Jaw pain or click (T.M.J.) R. L.
- _____ Head Seems too Heavy
- _____ Head & Shoulders Feel Tired
- _____ Difficulty in excessive (Standing, Walking, Sitting, Riding, Bending, Lifting, Twisting, Household Duties)
- _____ Shoulder pain R. L.
- _____ Dizziness
- _____ Ringing in ears R. L.
- _____ Hearing loss R. L.
- _____ Fainting
- _____ Loss of balance
- _____ Blurred or double vision R. L.
- _____ Upper back pain or stiffness R. L.
- _____ Mid back pain or stiffness R. L.
- _____ Low back pain or stiffness R. L.
- _____ Numbness, tingling or pain in buttocks, thighs, legs, feet, toes R.L.
- _____ Pain with cough, sneeze or strain at stools
- _____ Hip pain R. L.
- _____ Foot trouble R. L.

E
- _____ Chest pain
- _____ Asthma
- _____ Lung problems
- _____ Difficult breathing
- _____ Wheezing
- _____ Heart problems
- _____ Stroke
- _____ High or low blood pressure
- _____ Varicose veins
- _____ Liver trouble
- _____ Gall bladder trouble

F
- _____ Digestive problems
- _____ Excessive gas
- _____ Belching/bloating after meals
- _____ Heartburn
- _____ Ulcers
- _____ Diarrhea/constipation
- _____ Colon trouble
- _____ Hemorrhoids
- _____ Prostate problems
- _____ Impotence

G
- _____ Kidney trouble
- _____ Kidney stones
- _____ Frequent urination
- _____ Painful urination
- _____ Discharge
- _____ Menstrual problems/PMS
- _____ Menopausal problems
- _____ Breast lumps, soreness, discharge
- _____ Pregnant (now)
- _____ Bedwetting
- _____ Ear infections
- _____ Hepatitis
- _____ Venereal disease
- _____ AIDS/ARC
- _____ _____
- _____ _____
- _____ _____

Family history (mark F) **Your** history (mark with X)

Cancer_____Heart problems_____Stroke_____Seizures_____Scoliosis_____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Last Chiropractic care_____
Acupuncture Care_____
Medical Physical_____
Lab/Blood work_____
Gynecological _____

7 MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS