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.

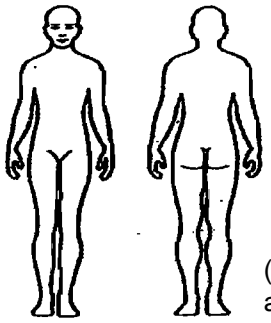
Reason for Visit_____

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)_____



(Please indicate after printing)

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: (Please fill out after printing)

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

If more space is needed, please continue on the back....

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
1.		
2.		
3		