Welcome To Bridgeport Chiropractic

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic and health concerns. Please print legibly and complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date_____ S/S _____-_____-_____
First MI Last

Address _____ City _____ State_____ Zip _____

Phone: Home (____) _____ Work (____)_____ Cell (____) _____
Do you prefer to receive calls at: □ Home □ Work □ Cell

Birthday: _____/_____/_____ □ Male □ Female □ Right Handed □ Left Handed

Are you: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed

Your employer_____ Occupation_____
At Work, Are You: □ Sitting □ Standing □ Active □ Sedentary
Who May We Thank for Referring You? _____
E-mail address (For newsletters or alerts):_____

WHAT BRINGS YOU HERE TODAY?

□ Neck Pain □ Headaches □ Middle Back Pain □ Lower Back Pain □ Shoulder Pain R/ L □ Elbow Pain R/L
□ Wrist / Hand / Finger Pain R / L □ Hip Pain R / L □ Knee Pain R / L □ Ankle Pain R / L □ Foot Pain R/ L
□ Other: _____

WHEN did your symptoms begin: _____
HOW did your symptoms begin: _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What describes the nature of your symptoms or pain?

□ Dull □ Sharp □ Achy □ Shooting □ Burning □ Numbness □ Tingling □ Restricted Motion/Stiffness

How are your symptoms changing? □ Getting Better □ Not Changing □ Getting Worse

Do Your Symptoms or Pain Interfere with: □ Work □ Sleep □ Sports □ Home life □ Bowel/Bladder

How bad are your symptoms: Today: 0_____10

(Please mark an X on the lines) **At worst:** 0_____10

Best ***Worst***

How do your symptoms affect your ability to perform daily activities? □ Mild □ Moderate □ Severe

What activities make your symptoms worse: □ Sitting □ Standing □ Walking □ Bending
□ Lying down □ Stretching □ Getting out of Bed, Chair or Car □ Stairs □ Other _____

What activities make your symptoms better: □ Sitting □ Standing □ Walking □ Bending
□ Lying down □ Stretching □ Ice □ Heat □ Medication _____ □Other _____

Have you seen anyone for this condition? □ Other Chiropractor □ Physical Therapist □ Medical Doctor

What treatment did you receive? □ Medication □ Corticosteroid Injection □ Muscle Relaxers □ Exercises

HEALTH HISTORY

Please check if you currently have or have you had any of the following medical conditions or procedures:

□Alcoholism	□Allergies	□Anemia	□Arthritis	□Asthma
□Cancer_____	□Diabetes	□Emphysema	□Epilepsy	□Glaucoma
□Headaches	□Heart Disease	□Hepatitis	□High Blood Pressure	□High Cholesterol
□HIV/AIDS	□Kidney Disease	□Kidney Stones	□Liver Disease	□Multiple Sclerosis
□Nerve Disorders	□Osteoporosis	□Seizures	□Stroke	□Thyroid Problems
□Tremors	□Tumors	□Unexplained Weight Loss or Gain		□Vertigo
□Low Back Pain	□Mid Back Pain	□Neck Pain	□Shoulder Pain	□Elbow Pain
□Hand Pain	□Hip Pain	□Knee Pain	□Ankle/Foot Pain	□Sinus Problems

□ Other Medical Conditions: _____

_____

Please list **ALL SURGERIES** with dates:

1. _____ 2. _____

3. _____ 4. _____

List any past **ACCIDENTS or FALLS** with dates: 1. _____

2. _____ 3. _____

Please list anything that you may be allergic to: _____

Please List **ALL MEDICATIONS**: _____

FAMILY HEALTH HISTORY:

Please list any significant health issue. (ie. Cancer, Stroke, Heart Disease, Diabetes, MS, Parkinsons)

Mother: _____ □ Living □ Deceased

Father: _____ □ Living □ Deceased

Brothers: _____ □ Living □ Deceased

Sisters: _____ □ Living □ Deceased

Grandmother (mother): _____ □ Living □ Deceased

Grandmother (father): _____ □ Living □ Deceased

Grandfather (mother): _____ □ Living □ Deceased

Grandfather (father): _____ □ Living □ Deceased

SOCIAL HISTORY

Do you take Supplements or Vitamins? □ Yes □ No Do you exercise? □ Yes □ No _____ hours per week

Do you □Smoke or □Chew Tobacco? □ Yes □ No How much? _____ How Long? _____

Do you Drink alcohol? □ Yes □ No □ Daily □ Socially □ Occasionally

Are you wearing: □ Shoe lifts □ Inner soles □ Arch supports Are you dieting: □ No □ Yes Since _____/_____

For Women: Are you taking Birth Control? □ Yes □ No

Are you pregnant? □ Yes □ No If so, how many weeks? _____ Are you nursing? □ Yes □ No

Signature: _____ Date: _____