Progressive Chiropractic Wellness Center
711 W. North Ave Suite 201, Chicago, IL 60610 tel:773-525-9355
www.progressivechiropractic.com

PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms.____
Last Legal First Middle Initial

Name you prefer to be called (nickname):__________________ Social Security #:__________________

Phone #:(___)__________________ Fax #:(___)__________________ Cell #:(___)__________________

E-mail:______________________________________ Driver's License #:__________________

Address:______________________ City:______________________ State:___ Zip:_________

Age:_______ Birth Date: ___________ Gender:_________ Patient's Employer: __________________

Work Address: ______________________ City:______________________ State:___ Zip:_________

Phone #: (___)______________Ext:_______ Occupation: ______________________________

Please circle: single/married/domestic partners/divorced/other:____________ Spouse/partner's name:__________________

Note: *Fill out this section only if insured is different than patient.* Name of Insured:__________________________

Relationship to insured: (please circle one): spouse/domestic partner child other:__________________________

Address:______________________ City:______________________ State:___ Zip:_________

Social Security #:______________________ Phone #:(____)__________________ Birth Date: _________

Insured's Employer (if different from patient): ____________________ Phone #:(_____)__________________

Work Address: ______________________ City:______________________ State:___ Zip:_________

PERSONAL HEALTH HISTORY

Have you ever been to a chiropractor before? No/Yes, what for?______________________________________

Who referred you to our practice? Person: _____________________ Advertisement:______________________

Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes

What do you hope to do better or enjoy more when you regain your health?_______________________________

____

When was your last physical exam?______________________Results:__________________________________

____

Date, and results, if known, of any recent tests: cholesterol:_______________other:______________________

Please list all current medications, vitamin/mineral supplements, herbs, including dosage:______________________

____

____

List any known allergies:____

If you smoke or have ever smoked, describe how much, and for how long:__________________________________

Describe your recreational drug use:__________________typical alcohol intake (#of drinks per day/per week):___________

Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):_____________________

____

____

Please list and describe all significant previous surgeries:____

____

____

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:___________

____

____

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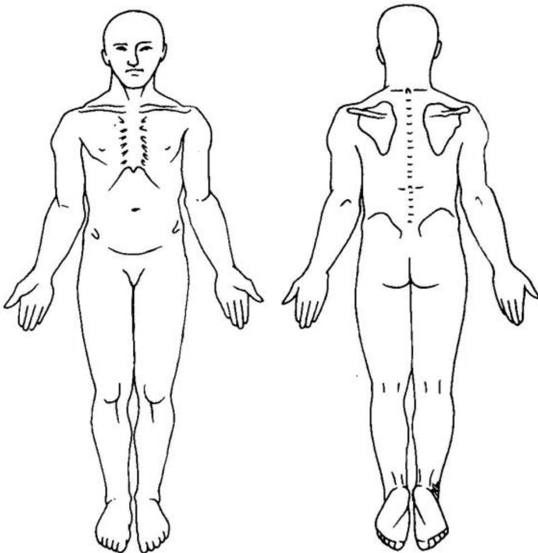
CHIEF COMPLAINT

Name: ______________________________ **Date:**__________ Condition #:______(use separate form for each condition)

1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury *someone else might be legally liable for*? Yes/No **Please Initial:**______ If yes, please fill out accident-specific form at the front desk
2. Please describe the nature of your condition at this time:____
3. When did your condition first begin? Year:_________Month:__________Day/Date:__________Time:______________
4. Cause of condition (circle all that apply): auto accident work injury sudden trauma reoccurrence repetitive trauma unknown/gradual other explain:_____________________________________
5. Have you had anything like this before? No/Yes: when?:_______________________________________
6. How often does the problem re-occur?:_______________________________________
7. Is the pain (circle): constant, on & off, usually lasting: ___minutes ___hours ____days ___weeks other:___________
8. Lately, has the pain been(circle): getting better getting worse staying about the same
9. Does the pain radiate?, to where:_______________________________________
10. What makes it feel better?_______________________________________
11. What makes it feel worse?_______________________________________
12. If you have seen another professional for this problem, or done any self-care, describe the type of treatment *and* results:___
13. At what time of day, week, or setting (home, recreation, work) is your pain worst?______________________________
14. Please list any activities you are unable to perform/have not performed due to the pain, or for fear of making the pain worse?
15. What else would you like the Dr. to know about you and/or your condition:______________________________

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:
ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST

1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY

1 2 3 4 5 6 7 8 9 10

FAMILY HISTORY

Please list any significant health problems of parents, grandparents, or siblings:____

____

REVIEW OF SYSTEMS

Please write a **number** in the spaces below: **1.**presently have **2.**previously had **3.**related to accident

GENERAL

______Frequent or recurring Chills
______Epilepsy/Convulsions/Seizure
______Frequent or recurring Dizziness
______Frequent or recurring Fainting
______Frequent or recurring Fatigue
______Frequent or recurring Fever
______Headache
______Frequent or recurring Sleep loss
______Recent Weight Change
______Anxiety/Panic Attacks
______Depression
______Frequent or recurring Sweats
______Frequent/recurring hives/rashes
______Frequent/recurring colds/flu
______Vertigo
______Fainting
______Fears/Phobias

GENITO-URINARY/ENDOCRINE

______Bedwetting
______Frequent urination
______Urinary tract infections
______Painful urination
______Painful menstruation
______Prostate trouble
______Loss of bowel/bladder control
______Gall Stones
______Blood in urine
______Thyroid problems/Goiter
______Kidney stones
______Irregular menstrual cycle
______Hot flashes
______Diabetes
______Pelvic Inflam. Dis.
______Infertility/Miscarriage

RESPIRATORY

______Spitting up phlegm
______Chest pain
______Spitting up blood
______Difficult breathing
______Asthma
______Wheezing
______Chronic cough
______Allergies

GASTROINTESTINAL

______Bloating, belching, gas
______Esophageal reflux
______Constipation
______Frequent heartburn
______Ulcer
______Digestive Problems
______Parasites
______Pain over stomach
______Diarrhea
______Vomiting
______Nausea
______Poor appetite
______Candida/Yeast
______Hernia

CARDIOVASCULAR

______Hardening of arteries
______High blood pressure
______Pain over heart
______Bad circulation/ankle swell
______Rapid heart beat
______Heart Disease
______Palpitation/Ireg heart beat
______Cold Hands &/or Feet

EYES, EARS, NOSE, THROAT

______Frequent/recurring sore throat
______Deafness
______Dental problems
______Ear problems/Infections
______Sinus problems
______Frequent/recurring nose bleeds
______Vision problems
______Canker sores
______Cold sores

MUSCULOSKELETAL – pain, numbness, weakness in:

______Low Back
______Neck
______Upper Back
______Mid Back
______Between Shoulder Blades
______Shoulder Blade: R/L both
______Shoulder: R/L both
______Foot: R/L bunions/corns
______Fibromyalgia
______Arm: R/L both
______Elbow: R/L both
______Hand: R/L both
______Leg: R/L both
______Hip: R/L both
______Knee: R/L both
______Ankle: R/L both
______Spinal curvature
______Arthritis/Gout

OTHER

______Absesses
______Acne
______Alcohol/Drug Addiction
______Anemia
______Athlete'sFoot/Fungal infection
______Cancer
______Chicken Pox
______Eczema
______Genital Warts
______Warts
______Hepatitis
______Scarlet Fever
______HIV
______Chicken Pox
______Dry/Cracked heels

OTHER

______Mononucleosis
______Psoriasis
______Sexually Transmitted Disease
______Whooping Cough
______Ingrown Toenails/Hang-nails

OTHER

______Genital Herpes
______Pnuemonia
______Sexual Abuse
______Worms
______Teeth Problems/Cavities

OTHER

______Mumps
______Root Canal/gumdisease
______Stroke
______Shingles
___Penile/Vaginal Discharge

OPTIONAL SECTION: NUTRITION

Height:____________ Present Weight:_____________ Weight one year ago:_________________ Preferred Weight:____________

Please indicate which you eat on a typical day: { }Breakfast { }Lunch { }Dinner # of snacks/day:__________________

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

_________Eggs
_________Cheese
_________Skim Milk
_________1% Milk
_________2%Milk
_________Whole Milk
_________Yogurt
_________Other:____

_________Red Meat
_________Pork
_________Fish
_________Ham
_________Beans
_________Chicken/Turkey
_________Tofu/Soy
_________Sausage/Lunch Meats

______Fruits
______Vegetables
______Desserts
______Grains,Rice,Pasta,Cereal,Bread
______Butter
______Margarine
______Nuts/Seeds/Peanut Butter
______Other:_________________

Fats/Oils:
______Canola ______Corn
______Olive ______Peanut___
______Safflower ______Sunflower
______Other:_________________
______Other:_________________
______Bacon/Hot Dogs, etc.
______Spicy Foods

Please indicate the estimated # of servings (6-8 oz. cups) of each of the following, which you drink on a typical day:

_________Caffeinated Coffee
_________Decaffeinated Coffee
_________Regular Tea
_________Regular Soft Drinks
_________Diet Soft Drinks
_________Herbal Tea
______Water
______Fruit Juices
______Sports Drinks (i.e.,Gatorade)
______Other:___________
______Other:___________
______Other:___________

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet:_______________________________

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: ___________

____

Was your special diet prescribed by a physician or nutritionist? Yes No ______________________________

Do you have success in following your special diet? Yes No explain:______________________________