HAWAII **CHIROPRACTIC** CLINIC

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www.HawaiiChiropracticClinic.com
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PATIENT INFORMATION

Name:_____ Date:_____

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

Social Security #:_____ Sex: [ ] M [ ] F Marital Status: [ ] M [ ] S [ ] D [ ] W

Age:_____ Birthdate:_____ Home Phone:_____ Email:_____

Who may we thank for your first visit? Referred By:_____

OR did you hear from us on: [ ] Newspaper [ ] Facebook [ ] Yelp! [ ] Website [ ] TV [ ] Other:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Spouse's Name:_____ Spouse's Birth Date:_____

Spouse's Social Security #:_____

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

Reason for today's visit:
[ ] New Injury [ ] Old Injury [ ] Chronic Pain [ ] Wellness

Are you in pain: Yes / No

Rate your pain with the following scale: (circle one)

None 1 2 3 4 5 6 7 8 9 10 *Intense*

WOMEN ONLY:
Are you pregnant? Yes / No How many months:_____

_____

Symptoms you have experienced in the past 6 months:

[ ] Low Back Pain
[ ] Pain Between Shoulder Blade
[ ] Neck Pain
[ ] Tension/Migraine Headaches
[ ] Tired/ Fatigued

[ ] Tension Across Top of Shoulders
[ ] Numbness/Tingling in Arms or Hands
[ ] Numbness/Tingling in Legs or Feet
[ ] Dizziness
[ ] Ringing of Ears

[ ] Nervous
[ ] Difficulty Sleeping
[ ] Allergies
[ ] Digestive Problems
[ ] Weight Problems

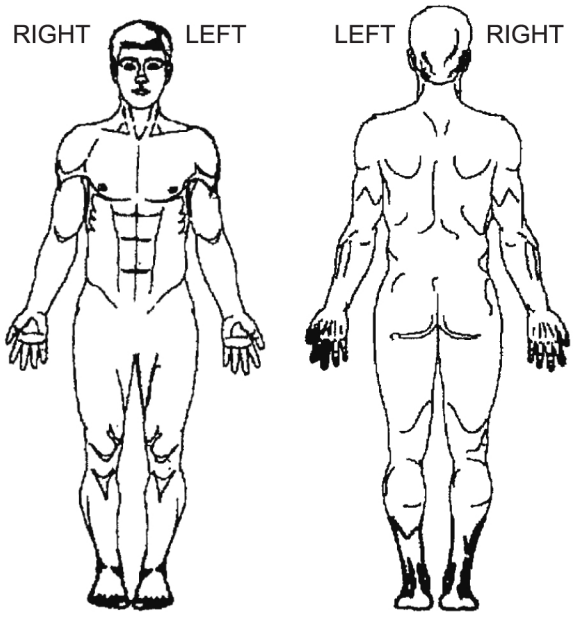
[ ] Other:_____

PAIN DIAGRAM

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

P.	PAIN
T.	TINGLING
N.	NUMBNESS
B.	BURNING
S.	STIFFNESS

FRONT **BACK**



Initial Here _____