

# Welcome To Aaragon Chiropractic

## Patient Information

Date \_\_\_\_\_ SS# \_\_\_\_\_

Name \_\_\_\_\_  
(Last)

(First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Status  Married  Single  Widowed  Divorced  Separated

Number of Children \_\_\_\_\_ Ages \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School \_\_\_\_\_

Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Previous Chiropractor \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Financial Policy Agreement

I understand that with the exception of work-related injuries, I am ultimately responsible for the payment of the services rendered to me at Aaragon Chiropractic.

(Signature) \_\_\_\_\_

Insurance Provider \_\_\_\_\_

## Are you taking medications?

Prescriptions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Non-Prescription: \_\_\_\_\_

Vitamins/Minerals: \_\_\_\_\_

## Daily Habits

### Do you...

- Smoke \_\_\_\_\_ packs a day  
 Drink Alcohol \_\_\_\_\_ drinks a day  
 Drink Caffeine/Coffee \_\_\_\_\_ drinks a day

### How is your...

- Stress Level: High Moderate Low None  
 Work Activity: Sitting Standing Light Labor Heavy Labor  
 Exercise Level: Heavy Daily Moderate None

## Phone Numbers

Home \_\_\_\_\_ Work \_\_\_\_\_

Cell or other \_\_\_\_\_

Best time and place to reach you: \_\_\_\_\_

### In case of emergency:

Name \_\_\_\_\_

Phone \_\_\_\_\_

## Health History

Please check all that apply:

- Diabetic  
 High Blood Pressure  
 Breast Implants  
 Pacemaker  
 Currently Pregnant

When did you last feel good? \_\_\_\_\_

## Patient Condition

Major complaint \_\_\_\_\_

Other complaints \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No

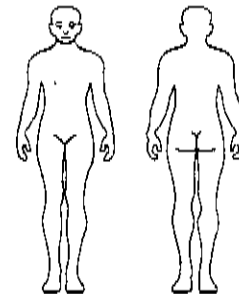
Is it constant or does it come and go? \_\_\_\_\_

Rate the severity of your problem on a scale from 1 (least) to 10 (severe pain) \_\_\_\_\_

Type of symptoms:  Sharp  Dull  Throbbing  Numbness  Aching  
 Shooting  Burning  Tingling  Stiffness  Other

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Mark on the picture where you continue to have symptoms



P= Pain N=Numbness S=Spasm T=Tingling

## Falls/Accidents/Injuries/Surgeries you had:

	Descriptions	Dates
Falls	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Dates of previous car accidents: _____		

### Please check your current symptoms:

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Irritability  | <input type="checkbox"/> Numbness in Toes        | <input type="checkbox"/> Face Flushed       | <input type="checkbox"/> Cold Hands / Feet   |
| <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Chest Pain    | <input type="checkbox"/> Shortness in Breath     | <input type="checkbox"/> Buzzing in Ears    | <input type="checkbox"/> Leg Pain            |
| <input type="checkbox"/> Neck Stiff    | <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Stomach Upset       |
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Sleeping Problems  | <input type="checkbox"/> Head Seems to Heavy |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Cold Sweats   | <input type="checkbox"/> Pins & Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Shoulder Pain       |
| <input type="checkbox"/> Nervousness   | <input type="checkbox"/> Ears Ringing  | <input type="checkbox"/> Pins & Needles in Legs  | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Tension       | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Other _____        |  |

**Date of last:** Physical Exam \_\_\_\_\_ Spinal Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ MRI / CT Scan \_\_\_\_\_

### Personal Injury Questionnaire

Accident Information	How did you feel...
Date _____ Time of Day _____ Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other To whom have you made a report of your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Police <input type="checkbox"/> Other Name of supervisor _____ Have you retained an attorney? _____	During the accident: _____ Immediately after the accident: _____ _____ Later that day: _____ The next day: _____

1. In your own words, please describe the accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Were you:  Driver  Passenger  Front Seat  Back Seat  Aware of the accident

3. Number of people in your vehicle? \_\_\_\_\_ Were you wearing seat belts? \_\_\_\_\_ Type of vehicle \_\_\_\_\_

4. Were you struck from:  Behind  Front  Left Side  Right Side

5. Approximate speed of your car? \_\_\_\_\_ mph Other car? \_\_\_\_\_ mph Damage to your car? \$ \_\_\_\_\_

6. Were you:  Unconscious Did you receive:  Cuts  Bruises  Other \_\_\_\_\_

7. What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic  None  Other

8. Name and address of other doctor(s) or facilities (ER, AMPM, etc.) you have seen concerning this condition: \_\_\_\_\_  
 \_\_\_\_\_

9. Have you lost time from work as a result of this accident?  Yes  No How Long? \_\_\_\_\_

10. Do you notice any activity restrictions as a result of this injury?  Yes  No

11. Is the pain worse when:  Working  Lifting  Stooping  Standing  Sitting  Bending  Coughing  Sleeping  Walking

Other Information: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 (Signature)

\_\_\_\_\_  
 (Date)