Welcome to Cranberry Chiropractic

file: _____
date: _____

First name: _____ Last name: _____
Address: _____ city/town: _____ zip: _____
Date of Birth: _____ Social Security Number: _____
Cell Phone _____ Home phone _____
Best number to contact: home cell work Work Phone: _____
email address: _____
Occupation _____ Employer _____

Marital Status: single married Name of spouse: _____
Children's names and ages: _____
How were you referred to our office? _____
friend family member flyer doctor sign ad

Your health history:

Subluxation is a dangerous condition which puts devastating pressure on your nerves and interrupts your nervous system. It keeps your body from healing and functioning properly for optimal health. Vertebral Subluxation can put damaging pressure on your nerves for a long period of time.

Current health complaints / reason for consultation and how long it has been bothering you

main complaint: _____ ☐ days ☐ weeks ☐ months ☐ years
2 _____ ☐ days ☐ weeks ☐ months ☐ years
3 _____ ☐ days ☐ weeks ☐ months ☐ years
4 _____ ☐ days ☐ weeks ☐ months ☐ years

Have you seen another Doctor for your main complaint? No Yes
if yes please indicate who and when:

_____

_____

Subluxations can cause irritation to different fibers within nerves.

How would you describe the pain of you main complaint? (circle all that apply)
sharp dull throbbing achy pinching stabbing burning _____

Please rate the pain of your main complaint on a scale of 1-10 (10=worst)
0 1 2 3 4 5 6 7 8 9 10

Does the pain from your main complaint radiate to any other body part? No Yes Where?

_____

Depending on the type and degree of subluxation the pressure on nerves can be constant or come and go.

How would you describe your main health concern?
Please check the one that best describes

- ☐ constant 100 % of time
- ☐ frequent 75 to 99% of time
- ☐ intermittant 25 to 75% of time
- ☐ occasional 0 to 25% of time

Is it? Please check all that apply.

- ☐ worse in morning
- ☐ worse in afternoon
- ☐ worse in evening
- ☐ worse after activity/work
- ☐ worse when relaxing
- ☐ worse when laying down or during sleep

Did you have any of these health problems as a child or teenager?

- ☐ broken or fractured bones (which bone) _____
- ☐ childhood illness (please specify) _____
- ☐ digestive issues
- ☐ ear infections
- ☐ headaches or migraines
- ☐ surgeries (what type) _____
- ☐ other health problem _____

Have you been diagnosed as having or suffering from:

☐ Arthritis	☐ Alcoholism	☐ Broken bone _____
☐ Allergies	☐ Circulatory problems	☐ Cancer _____
☐ Diabetes	☐ Depression	☐ Congenital disease: _____
☐ Drug Addiction	☐ Fatigue	☐ Headaches / migraines
☐ Heart Disease	☐ HIV positive	☐ Female/menstrual problems
☐ Mental Disorder	☐ Seizures /convulsions	☐ Gall Bladder Disorders
☐ Stroke	☐ Trouble breathing	☐ Gastrointestinal Problems
☐ Ulcer	☐ Urinary Problems	☐ Male /prostate problems

Please list any drugs you are taking, include prescription/over the counter and herbal or homeopathic medications: _____

_____

_____

Hospitilizations and surgeries (list type of injury or surgery and date)

_____

_____

Any conditions for which you are currently being treated:

_____

_____

The vast majority of our patients have experienced literally dozens of impacts that could cause vertebral subluxation. Please complete the following vital information.

When was your most recent auto accident? _____

Approximate speed ? _____

Was car hit ? Front Side impact Rear

What were your injuries? _____

What treatment was received (ie: hospital, chiropractic care, none)

_____

When was the auto accident before that (you may have been a child or learning to drive)

Date of accident (or your age if in childhood)? _____

Approximate speed ? _____

Was car hit ? Front Side impact Rear

What were your injuries? _____

What treatment was received (ie: hospital, chiropractic care, none)

_____

Most people have had a slip. Strain, twist or fall at work, whether it was reported or not,
when was your most recent stress or strain at work? _____

Please describe : _____

Was any treatment received? _____

Check all that apply to your work environment:

- ☐ heavy lifting
- ☐ lots of sitting
- ☐ lots of standing
- ☐ lots of computer time
- ☐ repetitive motion

What sports or recreational activities do you enjoy or played growing up?

☐ Baseball	☐ Gymnastics	☐ Swimming
☐ Basketball	☐ Hockey	☐ Soccer
☐ Bike Riding	☐ Martial Arts	☐ Tennis
☐ Dancing	☐ Rugby	☐ Volleyball
☐ Football	☐ Running	☐ Weight training
☐ Golf	☐ Skating	☐ other _____

When was your most recent slip, sprain or fall while playing sports? _____

Please describe : _____

What treatment was received (ie: hospital, chiropractic care, none)

_____

Please describe any slips, sprains or falls at home or elsewhere
(falls off your bike as a child, slips on the ice, fall down the stairs, etc)

_____

_____

Females: Are you or could you be pregnant at this time? Yes No Not Sure/Possibly

Who may we thank for referring you to our office?

If you are seeking care due to an auto accident, personal injury or worker's comp case (please circle)

Auto Accident Personal Injury Worker's Comp

If you have health insurance please present your card at the front desk. We will put it through our verification process and let you know how your insurance may participate in your wellness plan.

Thank you for your taking the time to complete this information, it is important to us and your care.

Patient Signature _____ date: _____