Miranda Chiropractic PATIENT INFORMATION

Patient Name:_____Today's Date:_____

What is your major complaint?_____

When did your symptoms start?_____

Is your condition the result of an AUTO ACCIDENT or A WORK COMP CLAIM? Y / N

If so, have you opened a Work Comp or Personal Injury Claim? Y / N Date of Injury?_____

Is it getting: ____BETTER ____WORSE ____STAYING THE SAME ____INTERMITTENT

What makes it worse?_____

What makes it better?_____

Rate the severity of your pain on a scale of **0** (No Pain) to **10** (Severe Pain) 0 1 2 3 4 5 6 7 8 9 10

Type of Pain: ____SHARP ____ACHING ____THROBBING ____SWELLING

____DULL ____SHOOTING ____TINGLING ____BURNING

____CRAMPING ____NUMBNESS ____STIFFNESS ____OTHER:_____

What other treatments do you use for pain?

☐ Medication ☐ Physical Therapy ☐ Chiropractic ☐ Massage

☐ Surgery ☐ None ☐ Other:_____

Have you experienced these symptoms before? Y / N When?_____

What other Doctors or Physicians have you seen for this condition?_____

Do you sleep on your side, back or stomach? _____Average hours of sleep per night?_____

How often do you exercise?_____What Type of Exercise?_____

FALLS:_____ YEAR:_____

HEAD INJURIES:_____ YEAR:_____

DISLOCATIONS:_____ YEAR:_____

BROKEN BONES:_____ YEAR:_____

SURGERIES:_____ YEAR:_____

Do you smoke?_____ Packs/day?_____ Do you consume caffeine?_____ Cups/day?_____

Do you consume alcohol?_____ Drinks/week?_____

Does your work include:

____Sitting ____Standing ____Light Labor ____Heavy Labor