Cole
Chiropractic & Wellness

DEMOGRAPHICS

Patient Name _____ Home Phone _____
Address _____ Cell Phone _____
City/State _____ Zip _____ Email _____
Date of Birth _____ Marital Status M S W D
Chief Complaint _____

INSURANCE

Name of Insured (if different than above) _____
Address of Insured (if different than above) _____
Are your present symptoms or conditions related to, or the result of an auto collision, work-related injury, or other personal injury? (Someone else might be responsible for payment?) ☐ yes ☐ no
Insurance Company _____ Ins Phone # _____
ID# _____ Group # _____
Name of Policy Holder _____ Policy Holder
Policy Holder's Employer _____ DOB _____

MEDICAL HISTORY

Family Physician _____ Phone _____
NOTE: May we send your health information to this provider? □ yes □ no
Have you ever been under chiropractice care? □ yes □ no When? _____
Have you had any spinal x-rays, MRIs, carpal tunnel syndrome taken in the last year? □ yes □ no Where? _____
Serious Illness? □ yes □ no When? _____
Infectious diseases? □ yes □ no When? _____
Health disorders/concerns? □ yes □ no _____

Do you have a pacemaker? □ yes □ no When? _____
Hip or knee replacements? □ yes □ no When? _____

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EMERGENCY CONTACT

Person to contact in case of emergency _____

What is your goal in this office? _____

_____

_____

_____ _____

Signature of Insured/Guardian Date

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Chief Complaint: _____

Secondary Complaint: _____

Other Concerns: _____

When did your your complaint begin? _____

How did your symptoms begin? _____

Circle what makes your symptoms worse: Bending Lying Walking Standing Sitting
Movement Twisting Lifting Sleeping

What makes your symptoms better? _____

How long do the symptoms last? _____

Have the symptoms improved? Become worse? Remained the same? _____

Have you had similar symptoms before? ___ If so, when?_____

What treatment did you receive? _____

Results of previous treatment? ____Good ___Poor Comments _____

Circle what describes symptoms: dull aching sharp shooting burning throbbing deep

Do your symptoms travel or radiate to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Do the symptoms stop you from doing any of your normal activities? _____
Work Sleep Daily Routines Recreation

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible)

Have you had any conditions in the past that have left you with ongoing problems?

_____

When do you have the symptoms? Worse in the morning? Night? No change? _____

_____

Any other Musculoskeletal concerns? ___No __Yes …Neurological concerns? __No __Yes

List any other major injuries you have had, other than those mentioned above:_____

_____

How did you find out about this office? _____

_____ _____

Signature Date

92 Portsmouth Ave., Suite 20, Exeter, NH 03833 603.422.5518 www.ColeChiropracticWellness.com

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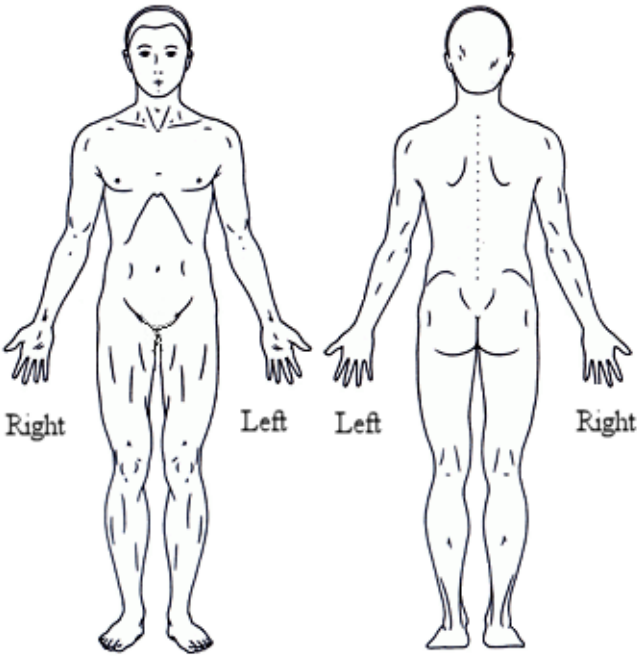
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =	
Dull Ache	OOO	
Burning		XXX
Sharp/Stabbing		/ / /
Pins, Needles	+ + +	
Other _____	^ ^ ^	

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

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Are you under medical care for any condition? _____

_____

What Medications are you taking? _____

_____

How long?_____ Have you had surgery?_____ What? _____

_____ When?_____

What side effects have you experienced from the drugs and surgery?

_____

Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date