Sailer Family Chiropractic

Date: / /

Personal Information (Please print):

Name _____ Prefer to be called _____
First MI Last

Address _____City _____ State _____ Zip _____

Home # _____ Cell # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Gender: ☐ Male ☐ Female

Date of Birth ___/____/_____ Age _____E-mail Address _____

Employer Information:

Name_____ Occupation_____ Work #_____

Emergency Contact:

Name _____ Address _____ Relation_____

City _____ State _____ Zip _____

Home #_____ Cell #_____

Insurance Information:

Health Insurance _____ ID Number _____

Group # _____ Name of Insured _____ DOB _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

From birth to present, please list by date and describe for the following:

- Have you ever had surgery or been hospitalized? ☐ Yes ☐ No
- Surgeries: _____
- Medications you take now _____
- Car Accidents _____
- Work Injuries _____
- Other Accidents _____
- Last X-rays _____
- Smoker ☐ Yes ☐ No

Have you ever had Chiropractic **care before?** ☐ **Yes** ☐ **No**
OR Acupuncture **care**? ☐ **Yes** ☐ **No**

- For what conditions: _____
- Name of Doctor_____ Reason for leaving: _____

Who can we thank for referring you to us? _____

Please select one: ☐ YellowBook ☐ SmartSearch ☐ Dex ☐ Internet(Google) ☐ Other_____

Patient History:

Please list your major complaints:	How long?	Is it getting (B) better (W) Worse or (S) Same?	Constant or Reoccurring?
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____

Did it occur while at work or from a motor vehicle accident? ☐ Yes ☐ No Did you report the incident? ☐ Yes ☐ No

What *aggravates* your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Sleeping ☐ Other_____

What *decreases* your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Sleeping ☐ Other_____

Does it cause pain to cough, grunt, or sneeze? ☐ **Yes** ☐ **No**

If yes, where? _____

Have you seen another doctor for this condition? ☐ **Yes** ☐ **No**

If yes, ☐ MD ☐ Physical Therapist ☐ Chiropractor ☐ Athletic Trainer ☐ Other_____

Does this condition affect your sleep? ☐ **Yes** ☐ **No**

In what position do you sleep? ☐ Back ☐ Stomach ☐ Side legs together ☐ Side with top leg higher

Describe your job duties_____

_____

How many hours do you work per week? _____

How many hours do you sit? _____ How many hours do you stand? _____

What percentage of the day do you have pain? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

What is your pain level, on a scale of 0-10? 1 2 3 4 5 6 7 8 9 10

What is your stress level, on a scale of 0-10? 1 2 3 4 5 6 7 8 9 10

Check, if you have experienced in the past 6 months.

☐ Neck Problems	☐ Sore Muscles	☐ Vision Problems	☐ Allergies
☐ Shoulder Problems	☐ Walking Problems	☐ Ear Pain/Noises	☐ Hay Fever
☐ Arm Problems	☐ Broken Bones	☐ Ear Infections	☐ Asthma
☐ Numbness-Arms	☐ Muscle Cramps	☐ Hearing Loss	☐ Eczema
☐ Pain between Shoulders	☐ Weak Muscles	☐ Tiredness/Fatigue	☐ Shingles
☐ Low Back Problems	☐ Loss of Feeling	☐ Frequent Colds	☐ Nausea/Vomiting
☐ Leg Problems	☐ Headaches	☐ Recent Fever	☐ Poor Digestion
☐ Numbness-Legs	☐ Dizziness	☐ Kidney Infection	☐ Ulcers
☐ Stiff Joints	☐ Fainting	☐ Menstrual Cramps	☐ Diarrhea
☐ Painful Joints	☐ Forgetfulness	☐ Blood Pressure	☐ Constipation
☐ Restricts Daily Activities	☐ Depression	Circle - High or Low	☐ Diabetes
☐ Restricts Regular Exercise	☐ Insomnia	☐ Chest Pain	☐ Acid Reflux

Other conditions not listed or anything you would like us to know? _____

If female, are you pregnant? ☐ Yes ☐ No ☐ Not Sure

On a scale of 1 to 10, with 10 being the highest, please rate your commitment in helping us solve this problem: _____