CULLEN CHIROPRACTIC & WELLNESS

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Patient Info Card — Welcome to our Office!

Name _____ Date of Birth _____ Age _____ ❑ M ❑ F

Social Security Number _____-_____-_____ ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Home Phone _____ Cell Phone _____ E-mail _____

Address _____ City _____ State _____ Zip _____

In case of emergency, contact

Name _____ Phone _____ Relationship _____

EMPLOYMENT

Current Status: ❑ Employed ❑ Full Time Student ❑ Part Time Student ❑ Retired ❑ Unemployed

Employer _____ Job Title _____

MEDICAL HISTORY

Hospitalizations _____

Surgeries/Medical Procedures _____

Accidents or Injuries (In the last 2 years) _____

(2+ years ago) _____

Ongoing Illness _____

Allergies _____

Previous Imaging (MRIs, x-rays) _____

Check any <u>MEDICATIONS</u> you are taking, including Over-The-Counter (OTC) & Prescription (Rx):

	OTC	Rx		OTC	Rx		OTC	Rx
Headaches	❑	❑	Diabetes	❑	❑	Bowels/Laxative	❑	❑
Pain	❑	❑	Water Pills	❑	❑	Hormones	❑	❑
Muscle Relaxants	❑	❑	Heart/Cardiovascular	❑	❑	Thyroid	❑	❑
Arthritis	❑	❑	Blood Pressure	❑	❑	Antibiotics	❑	❑
Steroids	❑	❑	Cholesterol	❑	❑	Birth Control	❑	❑
Sinus/Allergy	❑	❑	Ulcers	❑	❑	Heartburn/Stomach	❑	❑
Asthma/Bronchitis	❑	❑	Depression/Anxiety	❑	❑	Other _____	❑	❑
Sleeping	❑	❑	Psychological	❑	❑	**Not Taking Medications**	❑	❑

FAMILY HISTORY

Is there a family history of any of the following conditions?

❑ Heart disease ❑ Hypertension ❑ Cancer ❑ Diabetes ❑ Arthritis ❑ Other _____

SOCIAL HISTORY

Cigarettes/Tobacco ❑ None ❑ In the past ❑ Currently

Alcohol Use ❑ None ❑ Light/Moderate ❑ Heavy ❑ Former Alcoholic

Activity Level (Exercise) ❑ None ❑ Light ❑ Moderate ❑ Vigorous

How would you rate your stress level? ❑ Low ❑ Moderate ❑ High

Previous chiropractic care?

❑ No ❑ Yes, Dr. _____ When/where? _____

Signature _____ Date _____

NP Symptom Questionnaire

CULLEN CHIROPRACTIC & WELLNESS

Patient Name ____ Date ____________________

Complaint/Symptom Example: Low back Please specify left, right or bilateral (both)	1.	2.	3.
When did it begin? (days, weeks, months, years)			
How did it begin? Example: Exercise, car accident, etc.			
On a **scale of 1-10** (10 = worst) how bad does the pain get?	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
How often does the pain/symptom occur?	Constant Frequent Intermittent Occasional	Constant Frequent Intermittent Occasional	Constant Frequent Intermittent Occasional
Quality of the pain/ symptoms:	Achy Stiffness Burning Weakness Dull Tingling Sharp Numbness Stabbing Constricting Throbbing	Achy Stiffness Burning Weakness Dull Tingling Sharp Numbness Stabbing Constricting Throbbing	Achy Stiffness Burning Weakness Dull Tingling Sharp Numbness Stabbing Constricting Throbbing
Does the pain/ symptom **radiate**? Please specify left, right or bilateral (both)	Head - L / R Face - L / R Neck - L / R Shoulders - L / R Arms - L / R Hands - L / R Fingers - L / R Buttocks - L / R Hip - L / R Front thigh - L / R Rear thigh - L / R Calf - L / R Shin - L / R Ankle - L / R Foot - L / R Toes - L / R	Head - L / R Face - L / R Neck - L / R Shoulders - L / R Arms - L / R Hands - L / R Fingers - L / R Buttocks - L / R Hip - L / R Front thigh - L / R Rear thigh - L / R Calf - L / R Shin - L / R Ankle - L / R Foot - L / R Toes - L / R	Head - L / R Face - L / R Neck - L / R Shoulders - L / R Arms - L / R Hands - L / R Fingers - L / R Buttocks - L / R Hip - L / R Front thigh - L / R Rear thigh - L / R Calf - L / R Shin - L / R Ankle - L / R Foot - L / R Toes - L / R
What makes pain/ symptom **worse**?	Activity Twisting Bending Exercise Lifting Lying down Standing Movement Stress Sitting	Activity Twisting Bending Exercise Lifting Lying down Standing Movement Stress Sitting	Activity Twisting Bending Exercise Lifting Lying down Standing Movement Stress Sitting
What **relieves** the pain/symptom?	Ice Rest Heat Stretching Exercise Massage Laying Sitting Meds Standing	Ice Rest Heat Stretching Exercise Massage Laying Sitting Meds Standing	Ice Rest Heat Stretching Exercise Massage Laying Sitting Meds Standing