Family & Sports Chiropractic Group
BLAIR "Taking The Time To Care"
1185 Arthur Street, Eugene, OR 97402, (541) 343 - 7076

GENERAL INFORMATION FORM

Name: _____ **Date:** _____

Doctor's Signature: _____

GENERAL INFORMATION

Name: _____ DOB: _____ Age: _____ Gender: _____

Street Address: _____ City, State: _____ Zipcode: _____

Home #: ( ) _____ Cell #: ( ) _____ Marital Status: _____

Occupation: _____ Company: _____

Work Address: _____ Classification: ☐ full time ☐ part time

Emergency Contact: _____ Relationship to you: _____

Address: _____ Phone #: ( ) _____

How did you hear about us?: _____

PRIMARY PHYSICIAN

Do you have a primary care physician? Y N Name of Physician: _____

City, State: _____ Phone #: ( ) _____

Date of Last Office Visit: _____ Reason for Visit: _____

PREVIOUS CHIROPRACTIC CARE

Have you been treated by a chiropractor before? Y N Name of Chiropractor: _____

City, State: _____ Phone #: ( ) _____

Dates of Service: _____ to _____ Reason for Treatment: _____

What did NOT work?: _____

Have you had a/an...?

			Year(s)	Region of Body	Diagnosis
Y	N	X-ray *(non-dental)*			
Y	N	MRI			
Y	N	CT scan			
Y	N	ultrasound			
Y	N	bone density			
Y	N	nerve conduction			

Please list the location(s) of your test result(s):

Facility Name: _____ Facility Name: _____

Address: Address:

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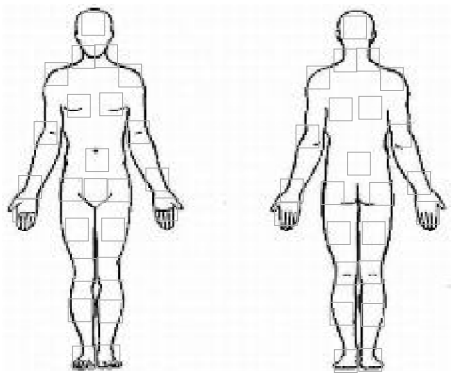
CHIEF COMPLAINT HISTORY FORM

Name: _____ **Date:** _____

Doctor's Signature: _____

LOCATION (circle EACH area of discomfort)



ONSET

My discomfort **began**: ☐ suddenly ☐ gradually

Approximate **onset date**:_____

My discomfort was **triggered** by:_____

_____

_____

_____

PREVIOUS EPISODES

Have you had this discomfort **before**? Y N

Date of **first episode**:_____

My discomfort usually occurs _____ times per year.

My discomfort usually last for _____ days.

QUALITY

Some **descriptor words** for my discomfort include:___

_____

_____

_____

TREATMENT

I have tried...			Start Date	# Sessions	Helpful?	
Y	N	physical therapy	_____	_____	Y	N
Y	N	massage	_____	_____	Y	N
Y	N	acupuncture	_____	_____	Y	N
Y	N	muscle relaxers	_____	_____	Y	N
Y	N	pain medication	_____	_____	Y	N
Y	N	steroid shots	_____	_____	Y	N

SEVERITY (for EACH area of discomfort)

no discomfort ----------> most discomfort imaginable

Average discomfort:

0 1 2 3 4 5 6 7 8 9 10

Maximum discomfort:

0 1 2 3 4 5 6 7 8 9 10

I feel **at least some discomfort** _____% of the day, with _____% of the day being **maximum** discomfort.

MODIFYING FACTORS

I feel **worse** when I:

Y	N	stand	Y	N	lift
Y	N	sit	Y	N	carry
Y	N	walk	Y	N	lay down
Y	N	run	Y	N	_____
Y	N	bend over	Y	N	_____

I **feel the best** when I:_____

_____

_____

EFFECT ON DAILY LIFE

Rate the following activities using the scale below:

cannot perform ------> perform to same degree as before injury

0 1 2 3 4 5 6 7 8 9 10

_____	work	_____	urinate
_____	study	_____	defecate
_____	bathe	_____	drive
_____	dress	_____	exercise
_____	concentrate	_____	socialize
_____	sleep	_____	eat
_____	groom	_____	cook
_____	clean	_____	Other_____

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SOCIAL & PAST HEALTH HISTORY FORM

Name: _____ **Date:** _____

Doctor's Signature: _____

Have you EVER experienced the following trauma?

			Year(s)	Injuries	Type of Treatment	Full recovery?
~~Y~~	N	car accident	_____	_____	_____	Y N
Y	N	work injury	_____	_____	_____	Y N
Y	N	sports injury	_____	_____	_____	Y N
Y	N	fracture	_____	_____	_____	Y N
Y	N	fall	_____	_____	_____	Y N
Y	N	surgery	_____	_____	_____	Y N

Additional space:

Label the medical conditions that you (X), your parent (P), grandparent (GP), or sibling (S) been diagnosed with.

Miscellaneous

_____ aneurysm
_____ blood clot
_____ cancer
_____ Crohn's disease
_____ chronic bronchitis
_____ diabetes
_____ emphysema
_____ gallbladder disease
_____ heart attack
_____ heart disease
_____ high blood pressure
_____ high cholesterol
_____ irritable bowel syndr.
_____ kidney disease
_____ liver disease
_____ migraines
_____ psoriasis
_____ sinusitis
_____ stroke
_____ tension headaches
_____ thyroid disorder
_____ ulcerative colitis

Other disorders not listed:

Nerves, Muscles, & Joints

_____ Alzheimer's
_____ ankylosing spondylitis
_____ Bell's palsy
_____ bursitis
_____ carpal tunnel
_____ cerebral palsy
_____ chronic fatigue syndr.
_____ dermatomyositis
_____ disc degeneration
_____ disc herniation
_____ epilepsy
_____ fibromyalgia
_____ gout
_____ Huntington's
_____ lupus
_____ Meniere's
_____ multiple sclerosis
_____ myasthenia gravis
_____ neurofibromatosis
_____ neuropathy
_____ osteoarthritis
_____ osteoporosis
_____ Parkinson's
_____ plantar fasciitis
_____ polymyositis
_____ reflex sympathetic dystr.
_____ rheumatoid arthritis
_____ sciatica
_____ scleroderma
_____ scoliosis
_____ Sjogren's
_____ spinal stenosis
_____ temporal arteritis
_____ tendonitis
_____ traumatic brain injury
_____ trigeminal neuralgia

List the medication, vitamins, and supplements that you are regularly taking.

Name	Year Began	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use or participate in...?

Y	N	recreational drugs	I've used _____ from ages _____ to _____.
Y	N	tobacco	I've smoked _____ pack(s) a day from ages _____ to _____.
Y	N	alcohol	I drink _____ to _____ serving(s) a week.
Y	N	exercise	I exercise _____ to _____ day(s) a week for _____ minutes.

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SYSTEMS REVIEW FORM

Name: _____ **Date:** _____

Doctor's Signature: _____

Have you experienced any of these symptoms in the past 3 MONTHS?

GENERAL:

Y	N	fever
Y	N	fatigue
Y	N	feeling "out of sorts"
Y	N	loss of appetite
Y	N	unexpected weight loss
Y	N	unexpected weight gain

NEUROLOGICAL:

Y	N	numbness
Y	N	tingling
Y	N	weakness
Y	N	shooting pain
Y	N	decreased coordination
Y	N	difficulty balancing
Y	N	decreased hot/cold sensation
Y	N	difficulty controlling urination
Y	N	difficulty controlling defecation
Y	N	decreased groin sensation

HEAD:

Y	N	fainting
Y	N	difficulty remembering
Y	N	difficulty concentrating
Y	N	seizures
Y	N	severe headaches
Y	N	dizziness

EYES:

Y	N	eye dryness
Y	N	eye redness
Y	N	blurred vision
Y	N	double vision
Y	N	blind spots
Y	N	"floaters"
Y	N	flashing lights

SKIN & LYMPHATIC:

Y	N	skin rashes
Y	N	changes in pigmentation
Y	N	lumps in neck region
Y	N	lumps in groin region

EARS:

Y	N	ear discharge
Y	N	ringing (tinnitus)
Y	N	difficulty hearing

THROAT & MOUTH:

Y	N	mouth sores
Y	N	mouth dryness
Y	N	hoarseness
Y	N	tooth problems
Y	N	difficulty swallowing
Y	N	difficulty speaking

NOSE & SINUSES:

Y	N	congestion
Y	N	frequent nose bleeds
Y	N	frequent sinus infections

HEART & LUNGS:

Y	N	wheezing
Y	N	shortness of breath
Y	N	cough
Y	N	sputum
Y	N	respiratory infection
Y	N	chest pain
Y	N	palpitations
Y	N	edema (swelling)

BLOOD:

Y	N	blood clots
Y	N	easy bruising
Y	N	easy bleeding

GASTROINTESTINAL:

Y	N	abdominal pain
Y	N	heartburn
Y	N	vomiting
Y	N	nausea
Y	N	constipation
Y	N	diarrhea
Y	N	hemorrhoids
Y	N	excessive flatulence
Y	N	red or black stools

GENITOURINARY:

Y	N	painful urination
Y	N	urine urgency
Y	N	increased urinary frequency
Y	N	urine retention
Y	N	urine dribbing
Y	N	excessive night urination
Y	N	red-tinged urine color
Y	N	frequent UTIs
Y	N	recent STD

ENDOCRINE:

Y	N	heat intolerance
Y	N	cold intolerance
Y	N	excessive urination
Y	N	excessive thirst
Y	N	excessive sweating
Y	N	brittle hair and nails

MENTAL STATUS:

Y	N	hallucinations
Y	N	insomnia
Y	N	anxiety
Y	N	depression
Y	N	suicidal thoughts

FOR MALES ONLY:

Y	N	impotence
Y	N	testicular pain
Y	N	penile discharge

FOR FEMALES ONLY:

Y	N	breast lumps
Y	N	vaginal sores
Y	N	abnormal vaginal discharge
Y	N	post-menopausal bleeding
Y	N	bleeding between periods
Y	N	pelvic pressure
Y	N	heavy menses
Y	N	absent menses
Y	N	painful menses
Y	N	painful intercourse

If you are a female patient, please answer the following questions.

Have you had your 1st period?	Y N	Age of 1st period:_____		Number of live births:	_____
Are you currently pregnant?	Y N	Number of weeks:_____		Number of miscarriages:	_____
Have you reached menopause?	Y N	Last period:_____		Number of ectopic pregnancies:	_____