Thacker Chiropractic Clinic

Patient Name: ___________________________________ Birthdate: _______________ Sex:
Address: _______________________________________ City: ___________________ State:
Zip: _________ Telephone: (____)____________Cell: (_____)______________ SSN # _______________
Occupation: _______________________ Employer: _______________________ Work: (_____)__________
E-mail: ______________________________

Describe your current problem and how it began:

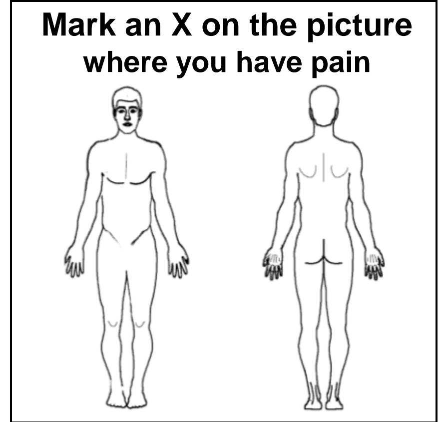
☐ Headache ☐ Neck Pain ☐ Mid-back pain ☐ Low back pain

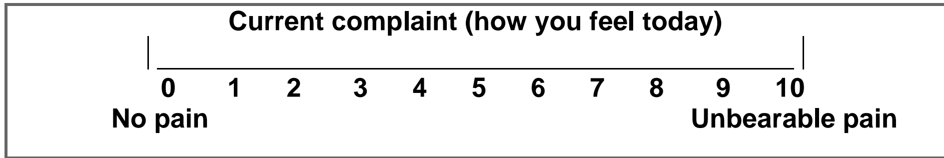
Is this: ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: ________________________________

How Problem Began: ________________________________

Mark an X on the picture where you have pain





Current complaint (how you feel today)

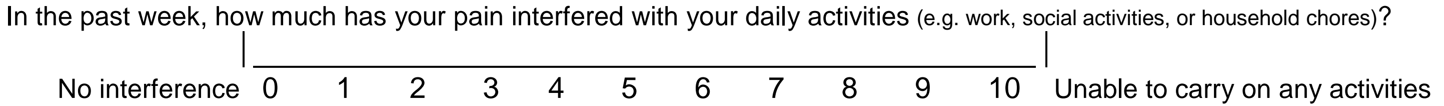
0 1 2 3 4 5 6 7 8 9 10

No pain **Unbearable pain**

How often are your symptoms present?

(Intermittent) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?



No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Have you had spinal X-rays, MRI, CT scan for your area(s) of complaint? No Yes

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) ____________________
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/ Fainting
☐ Numbness in Groin/ Buttocks
☐ Cancer/ Tumor (explain)
____
☐ Osteoporosis
☐ Epilepsy/ Seizures
☐ Other Health Problems (explain)

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at night
☐ Visual Disturbances
☐ Surgeries:

☐ Medications:

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/ Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinic peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician if necessary.

Patient Signature: ________________________________ Date: ____________________