WISE HEALTH
SOLUTIONS

Today's Date: _____/_____/____

Patient Information

Name: (First, Middle, Last) _____ Date of Birth _____

Address: _____ (City, State, Zip) _____

Social Security # _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____ Contact via email for appointments/reminders/events? ☐ Yes ☐ No

Employment Status ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other _____

How were you referred to Our Office? ☐ Patient ☐ Attorney ☐ by a Doctor ☐ Internet ☐ Other _____

Employment

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip) _____

Reason for Visit

☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness ☐ Other _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No Kinesiology's? ☐ Yes ☐ No

If so, whom? _____ Phone # _____

Insurance Information

Insurance Company: _____ Name of Insured: _____ DOB: _____

Relationship to the Insured: _____ Social Security # _____ Phone: _____

Attorney Information

Attorney's Name: _____ Phone # _____ Fax# _____

Address: _____

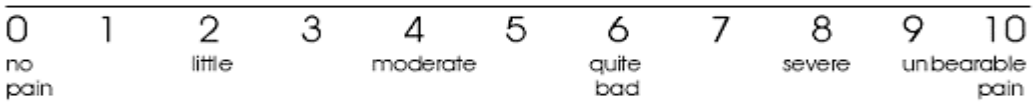
Additional Information: _____

Condition

Are you in pain? ☐ Yes ☐ No · Quality of the complaint: ☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Burning

☐Throbbing ☐ Deep ☐ Other_____

Rate your pain with the following scale:



Did your injury occur during: ☐ Work ☐ Sports ☐ Auto Accident ☐ Routine/Household Activity?

☐ Other _____

When did your condition/accident occur? ___ /___ /___

Where did your injury occur? _____

Please explain what happened:

_____

_____

_____

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes.

Is your condition interfering with your ☐ Work ☐ Sleep ☐ Daily routine? If so, how: _____

Has this or something similar happened in the past? ☐ Yes ☐ No · Please explain: _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

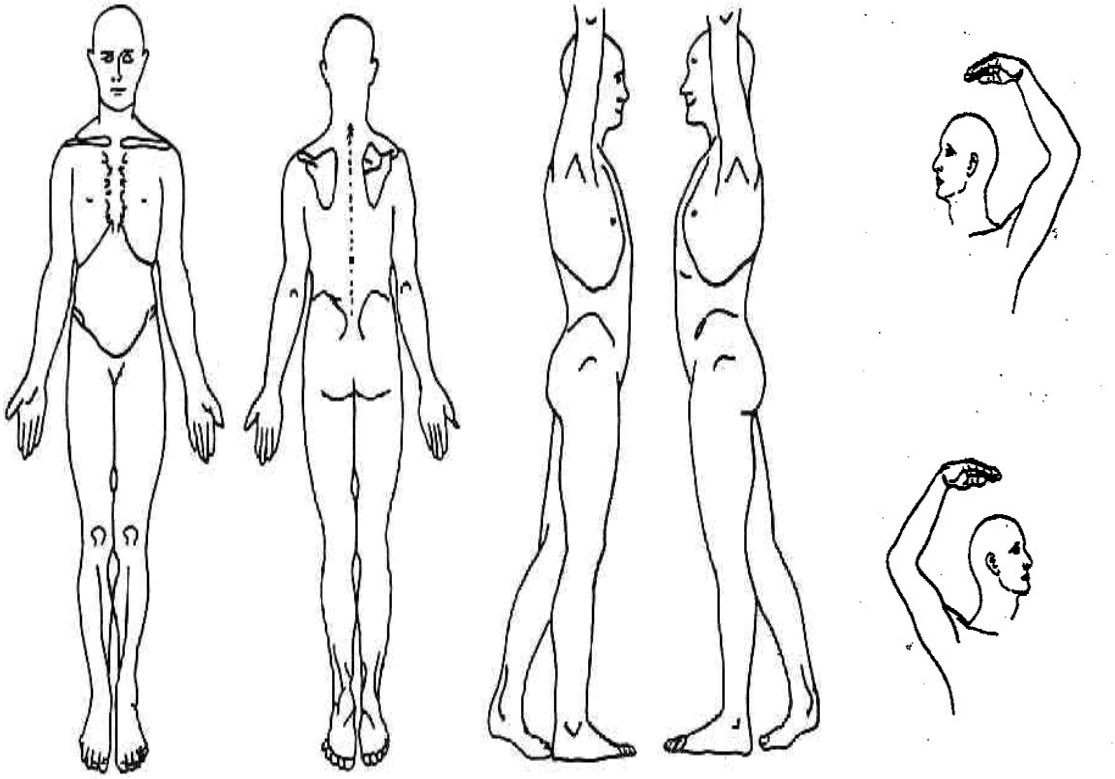
If so, where? _____

What were the recommendation /treatment? _____

What Medications are you taking? ☐ Pain Killers ☐ Muscle Relaxers ☐ Nerve Pills ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis ☐ Other(s), please list: _____

Name: _____ Today's Date: _____/_____/_____

Please fill in body outline to show where your pains are.



Area of Pain	Normal	Calm w/Pain			Moderate w/Pain			Severity w/Pain		
Neck	1	2	3	4	5	6	7	8	9	10
Middle Back	1	2	3	4	5	6	7	8	9	10
Lower Back	1	2	3	4	5	6	7	8	9	10
Waist	1	2	3	4	5	6	7	8	9	10
Hip	1	2	3	4	5	6	7	8	9	10
Shoulder	1	2	3	4	5	6	7	8	9	10
Legs	1	2	3	4	5	6	7	8	9	10
Head	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

_____

(Patient's Signature)