Chestnut Hill Chiropractic & Rehabilitation

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Today's Date: _____

Confidential Patient Information

Name: _____ Date of Birth: _____
First Last

Address: _____ Sex: M ☐ F ☐
Street (apt #)

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell Phone #: _____

Email: _____ Marital Status: M ☐ S ☐ D ☐ W ☐

SS #:_____ Student: Full-Time ☐ Part-Time ☐ Children: Yes ☐ No ☐

Spouses Name: _____ Emergency Contact: _____

Occupation: _____ Employer: _____

Insurance Company: _____ Policy #: _____

Group #: _____ Is this visit related to an accident? YES ☐ No ☐

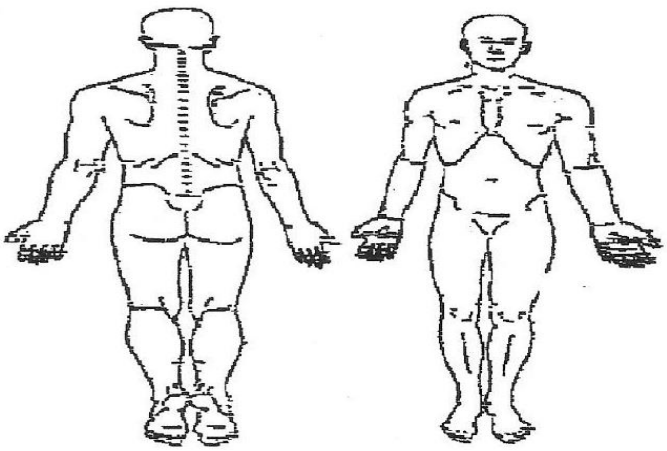
Major Complaints & Symptoms

When did your present conditions start? _____ Is this the first occurrence? _____
What aggravates these conditions? _____
What decreases these symptoms? _____

☐ Shoulder Pain L ☐ R ☐	☐ Knee Pain L ☐ R ☐	☐ Headaches	☐ Other
☐ Elbow Pain L ☐ R ☐	☐ Leg Pain L ☐ R ☐	☐ Mid Back Pain	_____
☐ Wrist Pain L ☐ R ☐	☐ Ankle Pain L ☐ R ☐	☐ Low Back Pain	_____
☐ Hand Pain L ☐ R ☐	☐ Foot Pain L ☐ R ☐	☐ Abdominal Pain	_____
☐ Hip Pain L ☐ R ☐	☐ Jaw Pain L ☐ R ☐	☐ Headaches	_____

On a scale of 1 to 10, how strong is the pain now? (1 being no pain and 10 being severe pain)

1 2 3 4 5 6 7 8 9 10



Using the symbols provided below, mark the areas on the illustrations where you are experienceing these sensations.

BURNING	XXXXXXXXXXX
STABBING	///////////////
PINS & NEEDLES	**********
ACHING	00000000000
NUMBNESS	- - - - - - - - - - - -