



**PHOENIXVILLE CHIROPRACTIC**  
1220 Valley Forge Road, Suite 5  
Phoenixville, PA 19403

Title: Miss / Mr / Mrs / Ms / Dr

First name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male / Female / Unspecified / Decline

\_\_\_Left Handed \_\_\_Right Handed

Women Only: Are you pregnant? YES / NO

Marital Status: Single Married Separated Divorced Widowed

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Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

I am: Employed Unemployed Student Retired

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Spouse / Auth. Rep / Guardian / Parent / Other

Contact Phone #: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone Number : \_\_\_\_\_

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Phoenixville, PA 19460

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary complaint: \_\_\_\_\_

What caused it: \_\_\_\_\_ Date of onset: \_\_\_\_\_

**On a scale of 0 to 10 with 0 representing no pain & 10 being the most severe pain imaginable, please rate your pain.**

0=None	1=Minimal	2=Very mild	3=Mild	4=Mild to Moderate	5=Moderate
6=Moderate to Severe	7=Mildly Severe, Restricts some activity	8=Severe	9=Very Severe	10=Excruciating	

**How would you best describe the sensation of the pain/symptom: (circle all that apply)**

Sharp	Dull	Stabbing	Aching	Burning
Throbbing	Numbness	Tingling/Pins & Needles	Weakness	

Does symptom radiate/travel? YES/NO If Yes, where? \_\_\_\_\_

Other: \_\_\_\_\_

**What aggravates the pain/symptoms? (circle all that apply)**

Bending	Changing Positions	Deep Breath	Driving	Exercise/Stretching	Household Chores
Lifting	Turning Head	Lying Down	Reaching	Running	Sleeping
Sitting	Standing	Straining	Stress	Twisting	Walking Up/Down Stairs

Other: \_\_\_\_\_

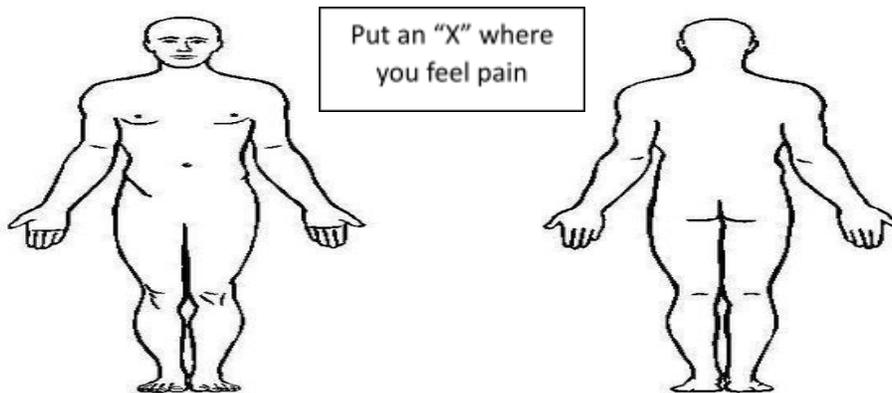
**What relieves the pain/symptoms? (circle all that apply)**

Back Brace/Belt	Exercise	Heat	Ice	Lying Down
No Movement	Changing Positions	NSAIDS	Movement	Pain Medication
Sitting	Stretching	Walking		

Other: \_\_\_\_\_

Over the past weeks/months this complaint is: \_\_\_Improving \_\_\_Getting worse \_\_\_About the same

Have you seen anyone for this condition? YES/NO Whom? \_\_\_\_\_



Any other areas of concern? \_\_\_\_\_

**Underlying Health Issues/Problems:**

Diabetes	History of Cancer	Heart Problems	High/Low Cholesterol
Arthritis	Prostate Problems	Thyroid Problems	Respiratory Issues
Neurological Issues	Headaches	Digestive Issues	High/Low Blood Pressure
Weight Loss/Gain	Osteoporosis/Osteopenia	Stroke	

Other: \_\_\_\_\_

**Women Only:**

# of Pregnancies \_\_\_\_\_ Menstrual Cycle Regular/Irregular

Birth Control Yes/No Menstrual Cramps Yes/No Other: \_\_\_\_\_

**Please List All Medications Rx & Over the Counter**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Injuries/Traumas - Please Include Motor Vehicles Accidents & Work Related Injuries:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my complaints and health concerns.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date