COFFMAN CHIROPRACTIC LIFE CENTER, P.C.

Current Personal Information Today's Date: ______________

Name: ______________________________ I go by: ____________ Sex: M F

SS#: ______________ Birth Date: ___________ Age: _____ Email: ____________________

Phone #: ________________ Work #: __________________ Cell #: ____________________

Address: ________________________________ City: ____________ St: _____ Zip: _________

Employer: ____ # of Years: _______

Occupation & Description *(include stressful activities)*:______________________________

____

Favorite Things to Do / Hobbies: ____

Referred by: ☐ Patient ____________________ ☐ Yellow Pages ☐ Yellow Book ☐ Other ____________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse or Significant Other: ______________________________________ Age: _____

Occupation of Spouse or Significant Other: ____________________________________

Name of Child (Age): ____________________( ) Name of Child (Age): ____________________( )

Name of Child (Age): ____________________( ) Name of Child (Age): ____________________( )

Symptoms

Major Complaint/s: 1) ________________________________2) ______________________

When did you first notice your complaint/s: 1) _______________________ 2) ______________

Which activities are difficult to perform?

☐ Sitting ☐ Bending ☐ Walking
☐ Standing ☐ Laying Down ☐ Other

____

____

What makes it feel better?

☐ Sitting ☐ Laying Down ☐ Heat
☐ Standing ☐ Walking ☐ Aspirin
☐ Bending ☐ Ice ☐ Other

____

____

The pain: ☐ is Constant ☐ Comes and Goes

Type of pain:

☐ Sharp
☐ Dull
☐ Throbbing
☐ Numbness
☐ Aching
☐ Shooting
☐ Burning
☐ Tingling
☐ Cramps
☐ Stiffness
☐ Swelling
☐ Radiating
☐ Other

____

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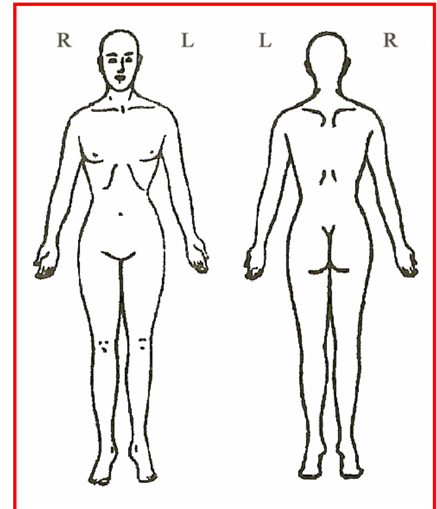

Please mark areas of pain

What treatment or treatments have you already received for your condition: ☐ None ☐ Medication ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ Other ____

Please rate your pain or discomfort on a scale of 1-10 *(10 being the most severe)*:____________________

Health History *(circle any that apply to you (S) or a family member (F))*

1. S F Alcoholism
2. S F Allergies
3. S F Anemia
4. S F Ankle/Foot Problem
5. S F Anorexia
6. S F Appendicitis
7. S F Arthritis
8. S F Asthma
9. S F Auto-Accident
10. S F Bladder Disorder
11. S F Bleeding
12. S F Breast Lump
13. S F Bronchitis
14. S F Bulimia
15. S F Blurry Vision
16. S F Cancer
17. S F Cataracts
18. S F Chicken Pox
19. S F Depression
20. S F Diabetes
21. S F Ear aches/Noise
22. S F Elbow Problems
23. S F Emphysema
24. S F Epilepsy
25. S F Fractures
26. S F Glaucoma
27. S F Goiter
28. S F Gout
29. S F Heart Disease
30. S F Headaches
31. S F Hepatitis
32. S F Hernia
33. S F Herniated Disc
34. S F High Cholesterol
35. S F Incontinence
36. S F Indigestion
37. S F Kidney Disease
38. S F Knee Problems
39. S F Liver Disease
40. S F Low Back Pain
41. S F Measles
42. S F Migraines
43. S F Miscarriage
44. S F Mononucleosis
45. S F Multiple Sclerosis
46. S F Mumps
47. S F Neck Pain
48. S F Osteoporosis
49. S F Pacemaker
50. S F Parkinson's
51. S F Pinched Nerve
52. S F Pneumonia
53. S F Prostate
54. S F Prosthesis
55. S F Rheumatic Fever
56. S F Shoulder Problems
57. S F Sinus Problems
58. S F Sore Throats
59. S F Stroke
60. S F Thyroid Problems
61. S F TMJ Problems
62. S F Tonsillitis
63. S F Tumors,
64. S F Growths
65. S F Ulcers
66. S F Other _________
67. S F Other _________

List any surgeries or serious injuries to date and when they occurred:____

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If you are a female, are you pregnant: ☐ Yes ☐ No

Daily Habits

What do your daily habits include? ☐ Smoking ☐ Long Hours of Sitting ☐ Long Hours of Standing

☐ Light Lifting ☐ Heavy Lifting ☐ Computer Work ☐ Other ______________________________

Do you sleep? ☐ On Stomach ☐ On Side ☐ On Back

How many hours of sleep do you get per night? ☐ < 5 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ > 12

How much Caffeine / Coffee _______________ Alcohol _______________Water _______________ do you consume daily?

What stresses might prevent you from getting the most out of your care? ☐ Time ☐ Money ☐ Work ☐ Other

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Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Corrective + Wellness Care). Your Doctor will weigh your needs and desires when recommending your care plan.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Corrective + Wellness Care

☐ Check here if you want the Doctor to select the type of care appropriate for your condition.

SIGNATURE: ____ DATE: _______________