In Motion Spine & Joint Center — Confidential Patient Information

5242 Main Street Spring Hill, TN 37174 Phone (615) 302-4747 Fax (615) 302-4748 Website: www.imsjc.com

Date:_____/_____/_____ Patient's Full Name _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children/Ages_____

Occupation:_____ Hours/Week_____ Employer:_____ Business Phone_____

Spouse's Name:_____Employer:_____ Business Phone:_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Family Physician: _____ City: _____ State:_____ Phone_____

Previous Chiropractic Care: ☐ Yes ☐ No Dr's Name _____ City/State:_____

Who can we thank for referring you to our office (Friend, Relative, Physician, Facebook, Google, etc):_____

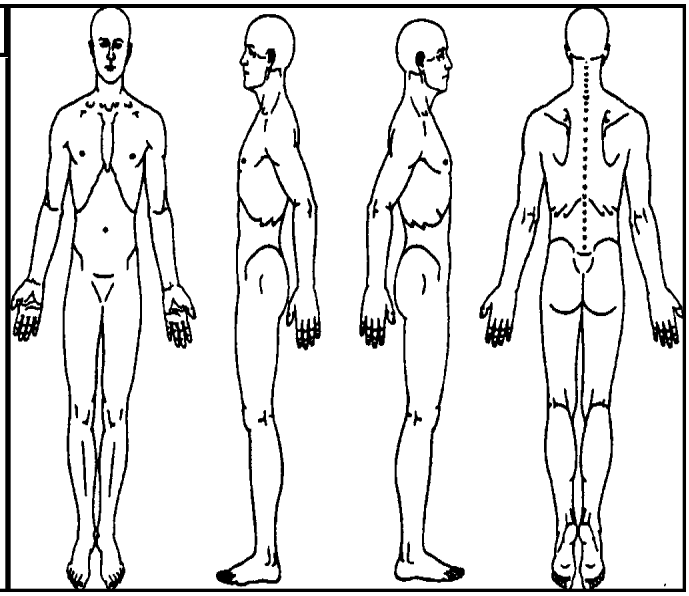
Have you had an X-ray/CT Scan within the last 12 months? If yes, did you bring the CD of images for the doctor to review? _____

How do you prefer to be reminded of your appointments?: ☐ Email ☐ Text
Cell Phone Provider (needed for text reminders) ☐ AT&T ☐ Sprint ☐ T-Mobile ☐ Verizon ☐ Cricket ☐ Next Tel ☐ Virgin Mobile

(**If yes to either question below, please check with receptionist, additional information is needed**)

Is Today's Visit Due To An On the Job, Work Related Injury: ☐ Yes ☐ No
Is Today's Visit Due To An Auto Accident: ☐ Yes ☐ No **Date Of Injury:**_____

****** Mark Your Areas of Pain on the Picture ******



SEVERITY OF PAIN

Chief Complaint: _____Onset Date:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

#2 Complaint: _____Onset Date:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

How did your **Chief Complaint** start? (ex. fell on ice)_____

What makes your pain worse? ☐ bending ☐ standing ☐ sitting ☐ walking Other:_____

What makes your pain better? ☐ laying down ☐ sitting ☐ standing ☐ walking Other:_____

What is the quality of your pain? ☐ sharp ☐ dull/ache ☐ throbbing ☐ tingling/numbness/burning ☐ Other:_____

What is the worst time for your pain? ☐ morning ☐ during day ☐ evening ☐ lying in bed ☐ Other:_____

How much of the day do you experience your chief complaint? ☐ 0 — 25% ☐ 25 — 50% ☐ 50 — 75% ☐ 75 — 100%

Has your current complaint caused any of the following: ☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory

Have you tried any self-treatment(ice, heat, exercises) or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain;_____Results:_____

What is your goal from treatment (e.g. play a round of golf without pain)?_____

_____

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Overall your **General Health** is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you ever experienced your present problem before: ☐ Yes ☐ No If yes, When:_____

Was treatment provided: ☐ Yes ☐ No If yes, By whom:_____ Outcome:_____

Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: _____

Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No If yes, explain:_____

Are you currently taking **anti-coagulant** or **blood thinning medication**? ☐ Yes ☐ No

Have you **ever** had any **major illnesses, injuries, hospitalizations, or surgeries?** ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Please List current **supplements or drugs** you may be taking: _____

_____

_____

_____

Systems Review Questions: place check marks by body areas or systems where you may have problems:

1. ____Eyes
2. ____Ears, Nose, Mouth, Throat
3. ____Heart
4. ____Lungs/ Breathing
5. ____Intestines/Bowels
6. ____Urinary
7. ____Muscles
8. ____Nerves
9. ____Joints/Bones
10. ____ Skin
11. ____Internal Organs
12. ____Blood
13. ____Allergies
14. ____Psychological/Emotional
15. ____Gynecological Menstrual/Breast
16. ____Prostate/Testicular/Penile

Please explain check marks:_____

_____

_____

Recreational Activities/Hobbies:_____

Your education level: ☐ Highschool ☐ Some college ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Yes	No		
☐	☐	Do you exercise? _____	Times per week
☐	☐	Use tobacco? Type_____	Packs/Cans per day (If you have quit, when did you quit?)_____
☐	☐	Consume alcohol?	How many drinks per week? _____
☐	☐	Have a healthy diet?	If no, explain: _____
☐	☐	Get adequate sleep?	If no, explain: _____
☐	☐	Is Work/School stressful to you?	If yes, explain: _____
☐	☐	Family life stressful to you?	If yes, explain: _____
☐	☐	Use recreational drugs?	If yes, explain: _____

FAMILY HISTORY AND HEALTH STATUS: list any diseases or major illnesses which affect your family (mother/father/sister/brother):

_____

How do you sleep ☐ Back ☐ Side ☐ Stomach Do you use a pillow : ☐ Yes ☐ No

Do you wear orthotics or arch supports ☐ Yes ☐ No

Females: Date of last gynecological and breast exam:_____

For X-Ray Purposes: Possible pregnancy? ☐ Yes ☐ No Date of last menstrual cycle: _____

I hereby state that all the information I have provided is complete and truthful and that I have fully disclosed my health history.

SIGNED: _____ Date:_____

Witnessed: _____ Date:_____