Dalton CHIROPRACTIC

2127 E 23rd Street
Fremont, NE 68025
Phone: 402-727-1677
Fax: 402-727-1678
DaltonChiro.com

Name:_____ Gender: M / F Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____ Other:_____

Email:_____ Please choose a 4 digit PIN for signing in:_____

Would you like an appointment reminder sent via ☐Text ☐Email ☐No Thanks

Employment Status: ☐Employed ☐Retired ☐Self Employed ☐Student ☐Other

Name of Employer or School: _____

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

How were you referred to our clinic? ☐Internet ☐Newspaper/Yellow Pages ☐Radio ☐Person:_____

Medical History

Who is your primary care Doctor? _____ City of Clinic_____

Please list all medications you are currently taking: _____

_____

_____

Please list all allergies:_____

Have you ever had any type of back surgery? Yes / No If so what type?_____

Where: _____ When: _____

Do you currently smoke: Yes / No How much/often? _____ Day / Week

Have you been diagnosed with Hypertension? Yes / No Have you been diagnosed with Diabetes? Yes / No

Please list all other health problems: _____

_____

Have you recently had an X-Ray, CT or MRI of your back? Yes / No
Where:_____ When:_____

Insurance/Payment Info

Are you the policy holder for your health insurance? Yes / No
If not; Policy Holders name:_____ Date of Birth:_____

Your relationship to the policy holder: _____Their Employer:_____

*** Please notify front desk if your bill will be paid by someone other than you***
Other paperwork may be required

Dalton
CHIROPRACTIC

2127 E 23rd Street
Fremont, NE 68025
Phone: 402-727-1677
Fax: 402-727-1678
DaltonChiro.com

Pain Assessment

What is your chief complaint? _____

What caused this complaint? _____

What % of the day do you notice this pain?
☐ Less than 25% ☐ 25% - 50% ☐ 50% - 75% ☐ 75% or more

Other Problem Areas - Please circle all that apply
Neck Shoulders Mid-Back Low-Back Legs Knees Other:_____

Does this pain radiate/shoot/travel to other areas? Yes / No
If so, where? _____

What is the intensity of your pain?
(Least Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

What type of pain do you experience?

☐ Dull ☐ Sharp ☐ Throbbing ☐ Burning ☐ Deep ☐ Aching
☐ Tingling ☐ Stabbing ☐ Cramping ☐ Numbness ☐ Radiating ☐Other

What do you do that would make your pain worse? _____

_____

_____

What do you do that makes your pain better? _____

_____

_____

Have you tried any of the listed interventions for this pain?

☐Surgery ☐Acupuncture ☐Chiropractic ☐Massage ☐Ice ☐Heat
☐Prescriptions Medication ☐Over the counter Medication ☐Homeopathic remedies

Is there anything else you would like your provider to know? _____

_____