808-888-2608

fun@epikchiro.com

EPIK CHIRO

(808) 888-2608 | FUN@EPIKCHIRO.COM

Date:_____

Name: _____ **Preferred Name:** _____
(First) (Middle) (Last)

Gender: □ Male □ Female **Birth Date:** _____ **Marital Status:** _____
(mm/dd/yyyy)

How were you referred to our office?: _____

E-Mail Address: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Contact #: _____ □ Cell □ Home □ Work □ Fax/Other

Secondary Contact #: _____ □ Cell □ Home □ Work □ Fax/Other

Health Insurance Information: **Occupation:** _____

Financially Responsible Party: □ **Self** □ **Spouse** □**Parent** □**Other:** _____

Policy Holder: _____ **Plan Name:** _____

Policy Number: _____ **Group Number:**_____

Date of Birth of Policy Holder: _____ **Effective Date:** _____

Address of Policy Holder: □ **Same as above** □ **Other:** _____ **Zip Code:** _____

Policy Holder Phone Number: □ **Same as above** □ **Other:** _____

Please list any of the following:

Medications: (e.g. blood pressure medication 20mg/day)

_____

Known Allergies, Dietary Restrictions and/or Preferences: (e.g. Daisy, Wheat, No Lactose, Vegan, Vegetarian)

_____

Vaccinations: (e.g. dates, type)

_____

Vitals: (If you do not know please indicate with a "?")

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Pulse:** _____ **Temperature:** _____

Timeline: **Please list dates, body location & reason (if never occurred please put "never")**

Surgeries: _____ **Disabled:**_____

Fractures: _____ **Hospitalizations:** _____

Last Spinal X-Ray: _____ **Dislocations:** _____

(Females Only) **Last Menses:** ___/____/____ **Currently Pregnant:** □ yes □no □ trying **Average days between Menses:** _____

Patient Initials _____

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Date:_____

Location/ Complaint: _____ □ **Left** □**Right** □**Center** □**Both**

Onset of Injury: ___/____/___ □ **within 1 month** □ **within 6 months** □ **one year** □ **over a year**

What is the cause of the injury (i.e. sports, fell down, etc.): _____

Pain/Symptom Intensity	0 (No Pain)	1	2	3	4	5	6	7	8	9	10 (Severe Pain)

Frequency: □ **Intermittent** □ **Occasional** □**Frequent** □**Constant**

Duration of complaint (i.e. 10 minutes, an hour, etc.): _____

Pain is the most frequent/intense in the: □ **morning** □ **midday** □ **night** □ **throughout day**

Pain Quality: (Mark all that apply)

□ Dull	□ Sharp	□ Throbbing	□ Burning	□ Deep	□ Aching
□ Tingling	□ Stabbing	□ Cramping	□ Numbness	□ Radiating	□ Stiffness

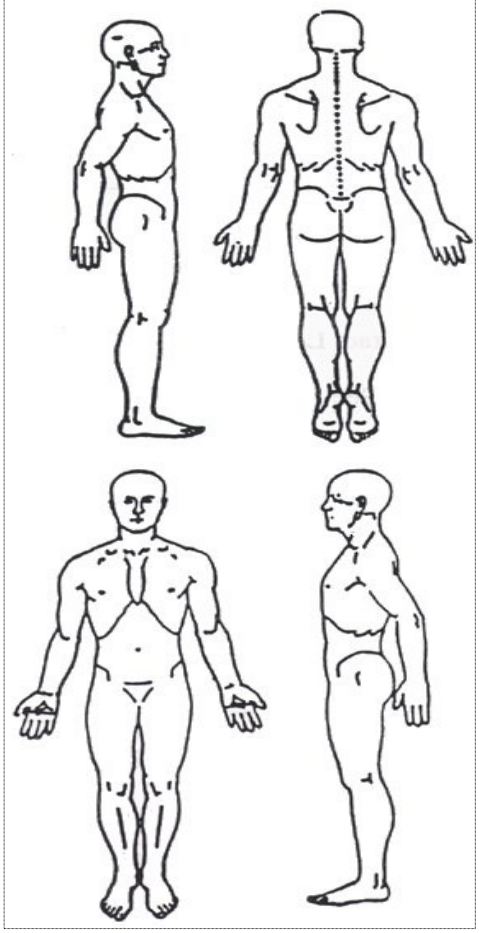
Aggravating Factors: (Mark all that apply)

□ Sitting	□ Standing	□ Walking	□ Bending	□ Stooping
□ Sleeping	□ Sneezing	□ Coughing	□ Straining	□ Reaching
□ Looking up	□ Looking down	□ Movement	□ Rest	□ Lying (face up)
□ Typing	□ Scooping	□ House chores	□ Exercise	□ Lying (face down)
□ Lifting	□ Twisting	□ Driving	□ Stair stepping	□

Relieving Factors: (Mark all that apply)

□ Sitting	□ Standing	□ Lying	□ Knees bent up	□ Support
□ No movement	□ Movement	□ Heat/Ice	□ Adjustments	□ Topical analgesic
□ Anti-Inflammatory	□ Medication	□ Rest	□ Stretching/ exercise	□

Circle all areas that need to be addressed:



Past or Current Problems (Check all that apply)

□Autoimmune disorders	□Cancers/Tumors/Cyst	□Kidney disorders	□Diabetes
□Allergies	□Cardiovascular diseases	□Thyroid Conditions	□Liver disorders
□Anemia	□Viral/Bacteria (e.g. Polio)	□Reproductive problems	□ Vision problem
□Arthritis	□Gastrointestinal disorders	□Respiratory conditions	□Asthmas
□Epilepsy/CNS/PNS	□Endocrine disorders	□_____	□_____

Family History (Check all that apply)

□Autoimmune disorders	□Cancers/Tumors/Cyst	□Kidney disorders	□Diabetes
□Allergies	□Cardiovascular diseases	□Thyroid Conditions	□Liver disorders
□Anemia	□Viral/Bacteria (e.g. Polio)	□Reproductive problems	□ Vision problem
□Arthritis	□Gastrointestinal disorders	□Respiratory conditions	□Asthmas
□Epilepsy/CNS/PNS	□Endocrine disorders	□_____	

Patient Initials _____