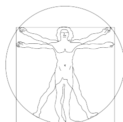


Wake Spine and Disc

DR. FLOYD CRITORIA

Patient ____
(First) (Middle) (Last)

Address ____

City ____________________ State ____________ Zip __________

E-mail address ____

Home Phone # ________________ Cell Phone # ________________

Referred by ____________________

Date of Birth ______________________________ Age __________
(Month) (Day) (Year)

Social Security # ______________________________________

Single( ) Married( ) Spouse's Name ______________________

Patient's Employer _____________________________________

Work Phone # ____

Insurance Company ______________________________________

Complaint ____

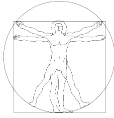
Is complaint accident related? Yes( ) No( ) Date accident occurred__________

Work related( ) Auto related( ) Other( ) ______________________

Payment Is Expected At Time Of Visit Unless Other

Arrangements Are Made In Advance

______________________ ______________________
Date Patient's Signature



Wake Spine and Disc

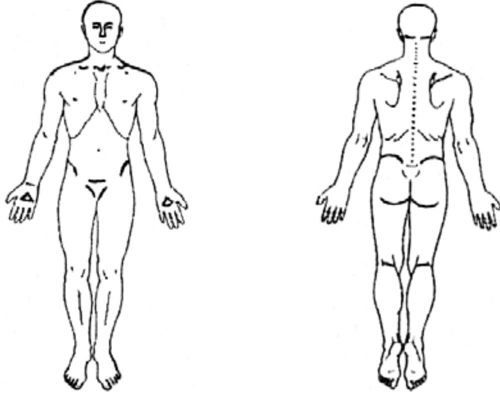
PATIENT HISTORY

Patient Name: ____ Date: ______________

Have you ever received Chiropractic Care? Yes or No If yes, when? _________________________________

Current Symptoms: ____

1. **Location** *(Where does it hurt?)* Circle the area(s) on the illustration



2. **Symptoms**

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other

3. **Intensity** *(What does it feel like?)*

○ ○ ○ ○

1 2 3 4 5 6 7 8 9 10

Absent Uncomfortable Agonizing

4. **Duration & Timing** When did it start? ________________________________ *How often do you feel it*? ☐Constant ☐Comes and goes

5. **Radiation** *(Does it affect other areas of your body? and what areas does the pain radiate, shoot or travel?)*

____

6. **Aggravating or relieving factors** *(What makes it better or worse, such as time of day, movements, certain activities, etc.)*

____

7. **Prior interventions** *(What have you done to relieve the symptoms?)*

☐ Prescription medication	☐ Surgery	☐ Ice
☐ Over-the-counter drugs	☐ Acupuncture	☐ Heat
☐ Homeopathic remedies	☐ Chiropractic	☐ Other________________________
☐ Physical Therapy	☐ Massage	

8. **What else should the doctor know about your current condition**?

____

9. Do you **CURRENTLY** experience **ANY** of the following?: **Date of last Physical Examination**: ______________________

☐ Urinary Problems	☐ Bowel Problems	☐ Night Sweats	☐ Fever	☐ Muscle Cramping
☐ Skin Rashes	☐ Blood Clotting Issues	☐ Sensitivity to Cold	☐ High Cholesterol	☐ Diminished Sex Drive
☐ Fainting	☐ Muscle Cramping	☐ Recurrent Infection	☐ Fatigue Easily	☐ Stomach Problems
☐ Migraines	☐ Kidney Problems	☐ Depression	☐ Anxiety	☐ Menstrual Irregularities
☐ Bladder Problems	☐ Weight Loss	☐ Chronic or Frequent	☐Cough	☐ Prostate Problems
☐ Dizziness/Vertigo	☐ Chest Pain	☐ Other ________________		

10. **Medical Conditions:**

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ AIDS/HIV
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke	☐ Hepatitis
☐ Osteoporosis	☐ Other ________________________________			

Doctor Signature ____, D.C.

Patient Name: ____ Date: _____________

11. Surgeries:

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical spine	☐ Hysterectomy	
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder	
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee	
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia	☐ Other ____________________

Have you had any X-Rays/CTs/MRIs or other special tests in the last year? ☐ Yes ☐No

Do you have ANY surgical hardware or implants (Pacemakers/Screws/Pins/Clips or Hip/Knee replacement?) ☐Yes ☐ No

12. Allergies:

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other ____________________

13. Medications/Supplements: *(what you are taking currently)*

☐ Blood Pressure	☐ Blood Thinning	☐ Arthritis	☐ Vitamins
☐ Cholesterol	☐ Hormone Therapy	☐ Over-the-counter meds	☐ Other ____________________

14. Social History:

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

15. Family History:

Arthritis:	☐ Parent	☐ Sibling	
Cancer:	☐ Parent	☐ Sibling	
Diabetes:	☐ Parent	☐ Sibling	
Heart Disease:	☐ Parent	☐ Sibling	
Hypertension:	☐ Parent	☐ Sibling	
Stroke:	☐ Parent	☐ Sibling	
Thyroid:	☐ Parent	☐ Sibling	Other ____________________________

16. Work History:

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Executive/Legal	
☐ Heavy Equip. Operator	☐ Light Manual Labor	☐ Construction	☐ Computer User	
☐ Food Service Industry	☐ Medium Manual Labor	☐ Daycare/Childcare	☐ Home Services	
☐ Manufacturing	☐ Heavy Manual Labor	☐ Health	☐ Housekeeper	☐ Other ________________

What types of activities does your job involve?

☐ Sitting ☐ Standing ☐ Bending ☐ Turning ☐Twisting ☐ Lifting ☐ Pulling/Pushing ☐ Other ________________

17. Are you currently pregnant? ☐ Yes ☐ No If yes, Due Date: ______________

18. Do you have a pacemaker? ☐ Yes ☐ No

Review & Consent

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with Chiropractic care, in accordance with this state's statutes. I understand that it is my responsibility to bring to the attention of the providing physician ANY new information regarding my health and well-being or any changes in health status that would be pertinent to my case management.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

Patient Signature ____ Date________________

Parent or Guardian Signature ________________________________ Date________________

Doctor Signature ____________________________________, D.C.