

# Welcome To Bluegrass Chiro of Lawrenceburg

Dr. Brian Schulz, D.C.

Date: \_\_\_\_\_

## Patient information

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

I give Bluegrass Chiro (,Dr. Brian Schulz, D.C.) Permission to contact me at the above numbers as well as leave a message if needed.

X \_\_\_\_\_  
Signature

Email Address: \_\_\_\_\_

\_\_ Check if you would like opt OUT of the text reminders

Gender: \_\_M \_\_F Age \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Birth Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

How did you hear about us? \_\_ yellow pages \_\_ Internet

\_\_ Person \_\_\_\_\_

\_\_ Other \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to patient? \_\_\_\_\_

Insurance: \_\_\_\_\_

Policy Holder Name? \_\_\_\_\_

## In Case of Emergency, Contact:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Number: \_\_\_\_\_

## Patient Condition

Reason for visit \_\_\_\_\_

Is your condition due to an accident? \_\_ Yes \_\_ No

Type of Accident: \_\_ Auto \_\_ Work \_\_ Home

Date pain began: \_\_\_\_\_

Is the condition getting: \_\_ Better \_\_ Worse \_\_ Staying the Same

Circle the number below showing how bad your pain is:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (I'd rather be dead)

Type of pain: (circle) Sharp Dull Achy Throbbing Burning

Shooting Numbness Tingling Cramping Stiffness Stabbing

\_\_ Other : \_\_\_\_\_

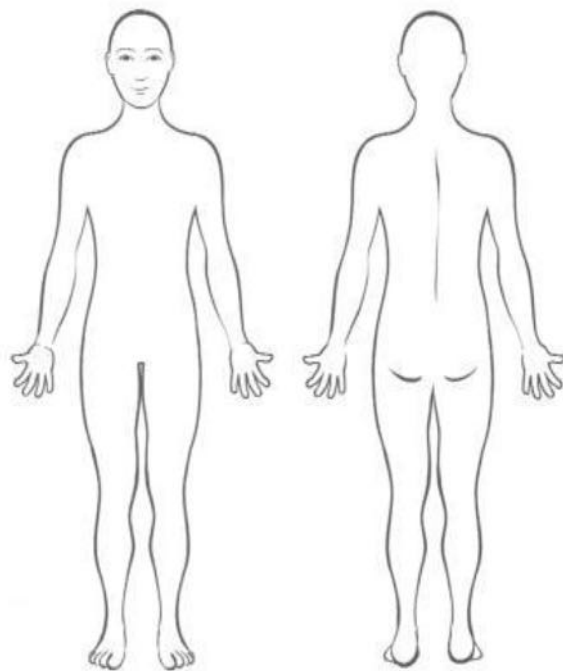
The Pain is: Constant or Comes and Goes

It is difficult to: Sit Stand Walk Bend Lay Down Drive Climb Stairs

My Pain Interferes with: Sleep Work Daily Activities Recreation

I feel better when I: Sit Stand Walk Lie down rest

Use Heat Use Ice Take Advil/Aleve/Ibuprofen/Pain Meds



Mark X on the picture where you have pain numbness or tingling.

## Health History

What treatment have you already received for this condition? \_\_\_ Medication \_\_\_ Surgery \_\_\_ Physical Therapy  
 \_\_\_ Chiropractic Services \_\_\_ None \_\_\_ Other \_\_\_\_\_

Name and address of other Doctors that have treated you for this condition \_\_\_\_\_

Date of last:    Physical Exam \_\_\_\_\_    Spinal X-Ray \_\_\_\_\_    Blood Test \_\_\_\_\_  
                     Spinal Exam \_\_\_\_\_    Chest X-Ray \_\_\_\_\_    Urine Test \_\_\_\_\_  
                     Dental X-Ray \_\_\_\_\_    MRI, CT Scan, Bone Scan \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid		Other _____	
Chemical				Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

### Exercise

\_\_\_ None  
 \_\_\_ Moderate  
 \_\_\_ Daily  
 \_\_\_ Heavy

### Work Activity

\_\_\_ Sitting  
 \_\_\_ Standing  
 \_\_\_ Light Labor  
 \_\_\_ Heavy Labor

### Habits

\_\_\_ Smoking                      Packs/Day \_\_\_\_\_  
 \_\_\_ Alcohol                        Drinks/Week \_\_\_\_\_  
 \_\_\_ Coffee/Caffeine              Cups/Day \_\_\_\_\_  
 \_\_\_ High Stress                    Reason \_\_\_\_\_

Are you pregnant? \_\_\_ Yes \_\_\_ No      Due Date: \_\_\_\_\_

Family Medical History: \_\_\_ Cardiac conditions \_\_\_ Diabetes \_\_\_ Cancer \_\_\_ Arthritis \_\_\_ Other \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____