# Welcome To Bluegrass Chiro of Richmond

Dr. Shawn Warren, D.C.

Date: _____

**Patient information**

Patient's Name: _____
Address: _____
City:_____
State:_____Zip_____
Home Phone:_____
Cell Phone:_____
I give Bluegrass Chiro (,Dr. Shawn Warren, 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)

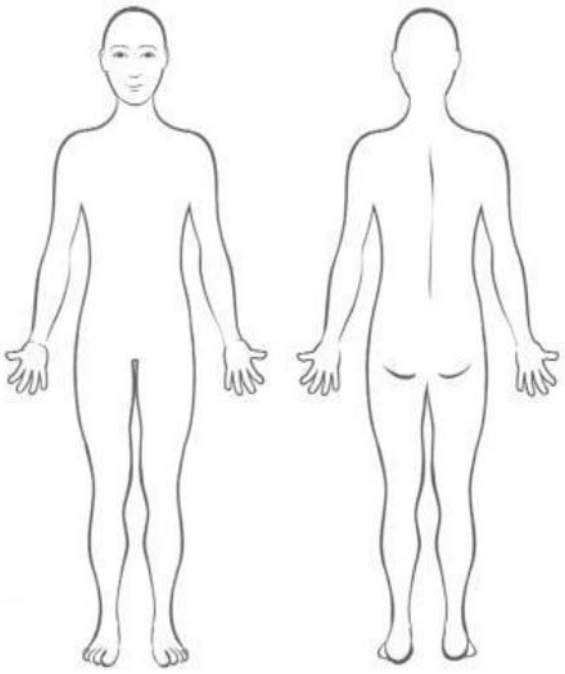
Type of pain: (circle) Sharp Dull Achy Throbbing Burning
Shooting Numbness Tingling Cramping Stiffness Stabbing
___ Other : _____

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

| **Exercise** | **Work Activity** | **Habits** | |
|---|---|---|---|
| __ None | __ Sitting | __ Smoking | Packs/Day _____ |
| __Moderate | __ Standing | __ Alcohol | Drinks/Week _____ |
| __ Daily | __ Light Labor | __ Coffee/Caffeine | Cups/Day_____ |
| __ Heavy | __ Heavy Labor | __ 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_____ | _____ | _____ |