UPRIGHT CHIROPRACTIC **Dr. Cory Hawkins | Dr. Jake Erickson** Today's Date _____

Confidential Patient Information Form

First Name _____ MI ___ Last Name _____ DOB _____ Age _____

Email _____ Cell _____ Home _____

Address _____ City _____ St ____ Zip _____

Occupation _____ Employer _____

Sex: M | F Marital Status: S | M | D | W Spouse Name _____

Children/Ages_____ How did you hear about us? _____

Emergency Contact _____ Relationship _____ Phone _____

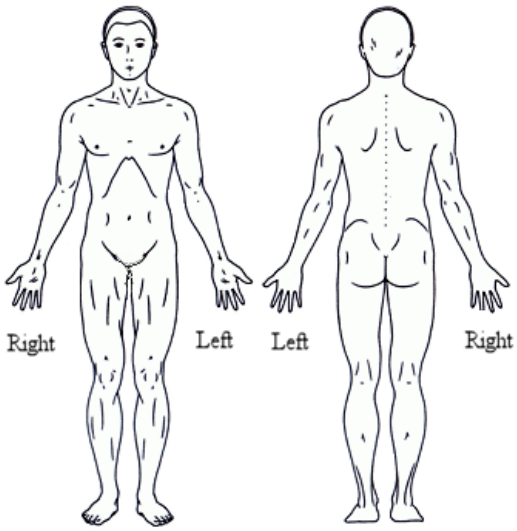
Previously received Chiropractic Care? Yes | No If Yes, by whom? _____

How Long? _____ When was your most recent care? _____

Please Circle your current pain level:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst possible pain)*

Using the symbols below, mark the pictures where you feel pain/discomfort.



Numbness = = =

Dull Ache O O O

Burning X X X

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

Doctor's Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

▪ Present Health Concern/Reason for Seeking Care: _____

▪ Onset of Pain/Problem: _____ ▪ Pains are: □ Sharp □ Dull/Ache □ Constant □ Intermittent

▪ Does this pain shoot, radiate, or travel in your body? Where? _____

▪ Are you experiencing numbness or tingling in any area of your body? Where? _____

▪ Is pain now: □ Same □ Better □ Worse ▪ Any home remedies tried? _____

▪ What activities aggravate your condition/pain? _____

▪ What activities lessen your condition/pain? _____

▪ Is this condition worse during certain times of the day? When? _____

▪ Is this condition interfering with: Work? _____ Sleep? _____ Routine? _____ Exercise? _____

▪ Other health professionals seen for this condition? _____

I hereby certify that the information given on this form is accurate to the best of knowledge, and I understand it is my responsibility to inform the chiropractor or his staff of any changes in my health. I agree to allow this office to examine me for further evaluation and to provide care.

Patient (or Guardian) Signature _____ Date _____