American Proactive Chiropractic
Rehabilitation Clinic

1640 Lancaster Dr. NE. Salem, Oregon 97301 503-339-7351☐

Today's Date____________

Patient Information

Name: (First, Middle, Last)____ Date of Birth:___________

Address: ____________________________________ City:____________ State:__________ Zip:________

Social Security #: ___________________ SEX: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐Widowed

Home Phone: _________________ Cell Phone: _________________ Work Phone: __________________

Emergency Contact: ____________________________ Emergency Phone: ______________________

Email: _________________________________Employment Status: ☐ Employed ☐ Student ☐ Unemployed

Pain Symptoms

☐ Headache	☐ Dizziness	☐ Memory Loss
☐ Vision Changes	☐ Ear Buzzing/ Ringing	☐ Tension
☐ Vomiting	☐ Nausea	☐ Fatigue
☐ Shortness of Breath	☐ Sleep Difficulty	☐ Jaw Problems
☐ Arm/ Shoulder pain	☐ Finger/ Hand numbness	☐ Feet/ Toe numbness
☐ Leg Problem R/L	☐ Irritability	☐ Neck Pain/ Stiffness
☐ Upper Back Pain/ Stiffness	☐ Mid Back Pain/ Stiffness	☐ Lower Back Pain/ Stiffness

Is your condition getting ☐ Worse ☐ Better ☐ unchanged

Please rate the severity of your pain (on average) from 0 (no pain) to 10 (worst pain) ______________

Type of pain ☐ Sharp ☐ Dull ☐ Aching ☐ Cramping ☐ Shooting ☐ Stiffness ☐ Throbbing ☐ Burning

☐ Swelling ☐ Numbness ☐ Tingling ☐ Other: ___________________________________

How often do you have this pain? ☐ Constant ☐ Intermittent

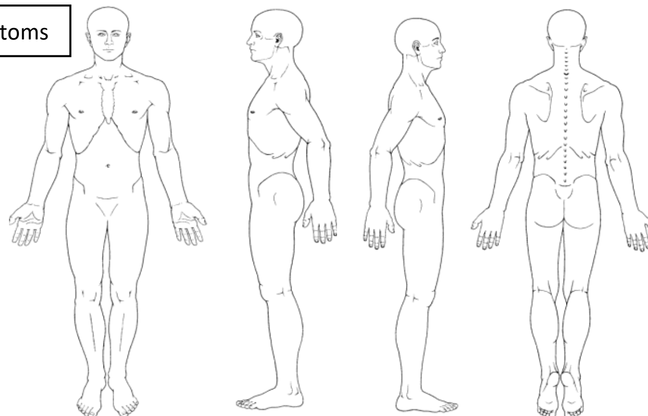
Does the pain interfere with your ☐ Work ☐ Sleep ☐ Recreation ☐ Activities of daily living

Pain Diagram

Please mark the areas in which you are experiencing symptoms

P = Pain
S = Stiff/ Sore
T = Tingling
Z = Sharp/ Shooting
N = Numbness

Mark with # 1-10. 10 – is going to the Hospital



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Medical History

Name: (First, Middle, Last) ____ Date of Birth:___________

Please check the box next to any of the conditions that you currently are suffering from or that you have had in the past.

General:

- ☐ Allergies
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weakness
- ☐ Other___________

Musculoskeletal:

- ☐ Arthritis
- ☐ Disc Herniation
- ☐ Hernia
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Sprain/ Strain
- ☐ Shoulders L/R
- ☐ Knees L/R
- ☐ Elbow L/R
- ☐ Wrists L/R
- ☐ Hands L/R
- ☐ Other ___________

Gastrointestinal:

- ☐ Appendicitis
- ☐ Belching or Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Digesting
- ☐ Excessive Hunger
- ☐ Gallbladder Trouble
- ☐ Hemorrhoids
- ☐ Intestinal Worms
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Ulcers
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Other___________

Other:

- ☐ Alcoholism
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Herpes
- ☐ Influenza
- ☐ Multiple Sclerosis
- ☐ Other__________

Cardiovascular:

- ☐ Angina
- ☐ By-Pass Surgery
- ☐ Chest Pain
- ☐ Cold Feet
- ☐ Cold Hands
- ☐ Heart Attack
- ☐ High BP
- ☐ Low BP
- ☐ Pacemaker
- ☐ Rapid Heartbeat
- ☐ Slow Heartbeat
- ☐ Stroke
- ☐ Swelling in ankles
- ☐ Other___________

ENT:

- ☐ Bleeding Gums
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Ear Noise
- ☐ Enlarged Glands
- ☐ Failing Vision
- ☐ Glaucoma
- ☐ Nose Bleeds
- ☐ Sinus Infection
- ☐ Sore Throat
- ☐ Other___________

Respiratory:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Spitting up Blood
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Other___________

Genitourinary:

- ☐ Bed wetting
- ☐ Bladder Infection
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Kidney Infection
- ☐ Painful Erections
- ☐ Prostate Trouble
- ☐ Pus in Urine
- ☐ Venereal Disease

Women Only:

Are You Pregnant?
☐ Yes ☐ No
If yes, How many months? __________

☐ Other__________

Pain or Numbness:

- ☐ Arms
- ☐ Buttocks
- ☐ Groin
- ☐ Hands
- ☐ Legs
- ☐ Face
- ☐ Feet
- ☐ Fingers
- ☐ Neck
- ☐ Shoulders
- ☐ Thigh
- ☐ Toes
- ☐ Other___________

Dermatological:

- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Dryness
- ☐ Easy Bruising
- ☐ Hives or Rashes
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins
- ☐ Other___________

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Past Health History

Name: (First, Middle, Last)____ Date of Birth:___________

Are you currently under the care of another physician? ☐ Yes ☐ No

If yes, who is your physician? ____

What are you being treated for? ____

Have you had any serious illnesses or major traumas in the past? ☐ Yes ☐ No

If yes, please describe: ____

Have you been hospitalized in the past? ☐ Yes ☐ No

If yes, please describe: ____

Have you had any prior car accidents in the past? ☐ Yes ☐ No

If yes, please describe: ____

Any continuation of pain or symptoms ☐ Yes ☐ No

If yes, please describe: ____

Have you seen a Chiropractor in the past? ☐ Yes ☐ No

If yes, please describe: ____

Have you had any prior X-rays or diagnostic imagine taken in the past? ☐ Yes ☐ No

If yes, please describe: ____

Women Only

Has there been any recent change in your menstrual cycle? ☐ Yes ☐ No

If yes, please describe: ____

Are you currently taking any medications?

☐ Prescription: ____

☐ Over the counter: ____

☐ Supplements/Vitamins: ____________________________________

Do you have any: ☐ Drug Allergies ☐ Food Allergies ☐ Seasonal Allergies

Have any of the following conditions been known to persist throughout your family:
☐ Cancer ☐ Hypertension ☐ Diabetes ☐ Arthritis
☐ Other ____

Habits	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Water	☐	☐	☐	☐

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I certify that this information is complete I give on this form and during my consultation is true, correct and complete to the best of my knowledge. If will not hold the clinic or the doctor responsible for any errors or omissions that I may have made in my answers.

Signature Consent

Patient or Legal Guardian Signature: ____ Date:___________

Staff Initials indicate the patient has received the following forms to read and review.

My signatures below recognize I have read and agree to the terms associated with the forms listed.

Financial Policy_______________________________ ______________ Staff Initial _________ _______
Patient Signature/Legal guardian Date Date

HIPPA Agreement ___________________________ ______________ Staff Initial _________ _______
Patient Signature/Legal guardian Date Date

Informed Consent ___________________________ ______________ Staff Initial _________ _______
Patient Signature/Legal guardian Date Date

Arbitration agreement________________________ ______________ Staff Initial _________ _______
Patient Signature/Legal guardian Date Date

Office Use ONLY

Pt out of pocket ☐ Pt use Insurance ☐ Notes: ____
____
____
____