NECK AND BACK CENTER 3441 PEACH ST ERIE PA 16508
(814) 864-2225 FAX: (814) 868-1199

Patient Introduction & History Sheet - reviewed by DR.________date__________
PLEASE FILL IN EVERY QUESTION. IF IT DOES NOT APPLY, MARK "NA"

Date__________________________________Name____

Address_____________________________________City___________________State______Zip________

Home Phone___________________Cell Phone________________________Work___________________

Birth Date________________________Age_________Social Security #____________________________

Sex: male female Occupation______________________Employer______________________________

Marital Status: married single divorced widowed # Children______ Height______ Weight______

Females (for X-Ray purposes): Is there a possibility you are pregnant? Yes No Last period__________

How did you hear about us:___Phonebook ___Sign ___Insurance Company ___Friend, If so whom______

______________________________ ___other____

Have you been to a chiropractor before? Yes No When___________Where________________________

Date of last X-Rays of neck _______ Midback_________Lowback_________Where taken_____________

Family dr name, address & phone____

List all surgeries, type & date____

List all medication & vitamins____

Any allergies including to med's____

Do you have a living will (physician's directive)? Yes No If yes, please provide us with copy for records

Family History (Self, mother, father, sister, brother, grandparents):

Neck or Back pain?____

Headaches?____

Cancer?____

Heart Disease?____

Other?____

Do you have difficulty with any of the following? Please **check** all that apply:

___shooting head pains ___grating in neck ___liver trouble

(please see back also)

Name_______________________________________Date______________________

___sinus trouble
___loss of smell
___allergies
___asthma
___loss of taste
___tightness of throat
___inflammation of throat
___thyroid trouble
___face flushed
___twitching in face
___loss of memory
___fatigue
___depression
___head feels heavy
___dizziness
___neck pain
___fainting
___loss of balance
___ringing in ears
___varicose veins

___tightness in shoulder
___pain into shoulder & arms
___pins, needles, numb in arms/hands
___cold hands
___chest pains
___shortness of breath
___tuberculosis
___heart pain
___heart palpitation
___mid back pain
___heart attack
___high blood pressure
___low blood pressure
___anemia
___rheumatic fever
___nervous stomach
___stomach trouble
___ulcers
___nervousness/anxiety
___fibromyalgia

___gallbladder trouble
___indigestion
___intestinal gas
___low back pain
___constipation
___kidney trouble
___menstrual pain
___irregular periods
___diabetes
___cancer
___sleeping difficulty
___painful joints
___swollen joints
___arthritis
___"slipped" disc
___"pinched" nerves
___pins, needles in legs
___swollen ankles
___cold feet
___irritable bowel syn.

What is the reason for your visit today:

If you are a new AUTO ACCIDENT or WORKMEN'S COMP PATIENT, you DO NOT need to answer the following questions.

List all other doctors, physical therapists, massage therapist, chiropractors or other professionals that you have seen for this problem and treatments including therapies, X-Rays, MRI, CAT Scans, medications for your problem.