

Bayside Chiropractic, pc
CONFIDENTIAL PATIENT INFORMATION SHEET
291 Waterman Street, Providence, RI
401-223-0111

Name _____ Date _____
Home Phone _____ Cell phone _____
Address _____ City _____ Zip _____
Age _____ Birth Date _____ Marital Status: M S W D # of Children _____
Occupation _____ Employer _____
Address _____ Office Phone _____
Driver's license-state and number _____

Name of spouse _____ Occupation _____
Employer _____ Office Phone _____

Emergency Contact _____ Phone _____

How did you hear about us? _____
Date of last physical examination _____

Have you been treated for any health conditions by a physician in the last year? Yes ___ No ___

Describe _____

Primary complaint _____

Is your current pain due to an automobile accident _____ Workers Comp accident _____
If yes, date occurred _____
Insurance company involved _____

Name of person responsible for payment _____
Contact info (if not patient) _____
Are you insured? Yes _____ No _____
Company _____

Patient's Signature _____ Soc. Sec. # _____

Guardian's Signature Authorizing Care (if applicable) _____

Please update our office as to any changes in your address, phone numbers or insurance information promptly.

Bayside Chiropractic, PC Patient History Form

Name _____ Date _____

Age _____ Sex: M F Height _____ Weight _____

Purpose of this appointment? _____

Major Complaint or Concern? _____

Date you first noticed symptoms? _____

Describe the pain? _____

How often does it bother you? _____

When during the day or night does it bother you? _____

When it hurts, how long does it last? _____

What makes it worse? _____

What makes it better? _____

What do you think caused the Problem? _____

Have you had this before? _____ How long did it last? _____

What did you do for it? _____

What activities is this preventing you from doing? (at work, home, socially, as a parent, as spouse, sexually, other) _____

Is this condition getting progressively worse? Yes ___ No ___ Constant ___ Comes and goes ___

Have you been to a physician for this problem? Yes ___ No ___ Who? _____

Have you been to a Chiropractor before? _____

List previous diagnoses and treatments you have received for the present condition _____

What do YOU think the problem is? _____

Have others in your family had a similar complaint? _____

Do you have any other complaints? _____

Age of your mattress? _____ How well do you sleep? _____

hours/night _____

Are you wearing? Heel lifts ___ Sole lifts ___ Inner soles ___ Arch Supports ___ Other ___

What illnesses do you suffer from now? _____

Please list any allergies _____

cups you usually drink/day? Water ___ Soda ___ Coffee ___ Tea ___ Juice ___

Current medications (include home remedies, prescription, nonprescription drugs and the

Bayside Chiropractic, PC Patient History Form

purpose for taking them) _____

Tobacco use: Never smoked _____

I quit _____ years ago, I smoked _____ packs/day for _____ years.

Currently smoking _____, I smoke _____ packs/day (for _____ years.)

Alcohol use: Last week I drank: _____ beers, _____ mixed drinks, _____ glasses of wine.

Please list any past sprains or fractured bones? _____

Please list any hospitalizations or surgeries? _____

Have you had any emotional or psychological problems? _____

Please check if you have had the following:

____ measles ____ rubella ____ mumps ____ whooping cough ____ chicken pox

____ rheumatic fever ____ scarlet fever ____ polio ____ hepatitis ____ VD

____ HIV ____ diabetes ____ cancer (where?) _____ other _____

Family History: Please indicate if you or any family members have had any of the following.

Include parents, grandparents, siblings, children, and spouse. PLEASE INDICATE WHO.

Cancer (type) _____

Heart disease _____ Stroke _____ Diabetes _____

Kidney disease _____ Tuberculosis _____ High blood pressure _____

Arthritis _____ Ulcers _____ Epilepsy/seizures _____

Headaches _____ Anemia _____ Lung Disease _____

Muscle, bone, or nerve disease _____

REVIEW OF SYSTEMS: Please circle anything that you are currently experiencing (or fill in the blank).

GENERAL:	Weight gain	Weight Loss	Difficulty maintaining Ideal weight
	Fever Chills	Night sweats	Lack of Energy
	Frequent Illness	Body Odor	Bad Breath Poor Resistance to disease
	Low Endurance during activity		Slow recovery from Illness
	Problems with yeast/fungus		Food/chemical sensitivities

SKIN: rashes lumps sores itching dryness color change
 changes in hair or nails Complexion problems Brittle/easily broken fingernails
 Dry/damaged/dull hair

HEAD: headache head injury jaw pain hair loss

EYES: vision problems glasses contact lenses pain redness dryness
 watery double vision floaters flashers Bags under eyes
 last eye exam _____

EARS: hearing loss ringing buzzing dizziness discharge pain

NOSE/SINUSES: discharge allergy bleeding stuffiness pain excessive mucus

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BREASTS: dimpling lumps discharge pain regular self exams? (Yes ___ No ___)

CHEST: pain/discomfort palpitations difficult breathing asthma/wheezing cough
excessive mucus spitting up blood or phlegm exposure to air pollution

GASTROINTESTINAL: difficulty swallowing heartburn gas or belching after meals
abdominal pain nausea bloating
difficulty digesting certain foods Frequent use of antibiotics
Cravings for sweets or processed foods Food allergies
Regular consumption of dairy products vomiting
Lack of appetite High-fat diet Frequent consumption of red meat
Poor eating habits Low-fiber diet Heavy caffeine consumption
irregular/infrequent bowel activity constipation
diarrhea fatty/floating stool hemorrhoids

URINARY TRACT: kidney pain painful urination incontinence blood in urine
frequent urination wake up at night to urinate (# of times ___)

GENITOREPRODUCTIVE: pain discharge herpes swelling low sex drive

Women: date of last period _____ PMS hot flashes irregular cycles
Are you or do you think you are pregnant? _____
Menopausal concerns _____ Monthly female concerns _____
Have you had? C-section _____ hysterectomy _____

PERIPHERAL VASCULAR: swelling of feet or legs cold hands cold feet blue fingers
cramps with walking numbness varicose veins

MUSCULOSKELETAL: Sore or painful joints muscle cramps limited motion stiffness
sore muscles swollen joints sciatica numbness
paralysis weakness tingling

HEMATOLOGIC: bruise easily bleed easily date of last blood work _____
Cholesterol level if known _____

ENDOCRINE: Skin getting darker excessive thirst, hunger, or urination
weakness or fatigue ankle swelling

MENTAL STATUS: Depression Frequent mood swings Stressful lifestyle
Feeling low or un-interested Unsettled, apprehensive, pressured
Easily angered/irritated excessive worry Nervousness
Poor concentration/memory Feeling out of control