Sandoz Chiropractic Center
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Mount Laurel, NJ 08054
PH: 856-206-9560 Fax: 856-206-9701
www.sandozchiropractic.com
frontdesk@sandozchiropractic.com

Welcome To Sandoz Chiropractic Center
CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Maiden Name: _____

Race (choose one): [Asian] [African American] [Caucasian] [Hispanic] [Native American] [Other]

Ethnicity (choose one): [Non-Hispanic] [Hispanic] [Withheld]

Address: _____ Postal Code: _____

City _____ State: _____ E-mail address: _____

Appointment reminder preference: [Cell Phone Call] [Home Phone Call] [Text Message] [E-mail]

(Circle more than one above if you would prefer that)

Home Phone _____ Work Phone _____ Cell Phone _____

Cell phone carrier (for text messages) [AT&T] [Verizon] [Sprint] [Virgin] Other _____

Date of Birth ___ / ___ / ___ Social Security Number ___ - ___ - ___

Gender: [Male] [Female] Height: ___ ft ___ in Weight: ___ lbs.

Married Single Divorced Widow(er) Number of Children Pregnant: Due Date:

Employer _____ Occupation _____

Emergency Contact: _____ Contact Phone # _____

Whom may we thank for referring you? _____

Primary Care Doctor: _____ Phone: _____

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____

List all accidents or injuries:

Type _____ When _____ Hospitalized? _____

List all surgeries:

Type _____ When _____

List medications and/or vitamins and supplements you are taking

Name _____ For _____ How long _____

Name _____ For _____ How long _____

Use back of sheet for any additional space needed.

PAIN DRAWING

Name:_____ Date:_____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark the area of radiating pain, and include all affected areas. You may draw on the face as well.

Pain Symbols:

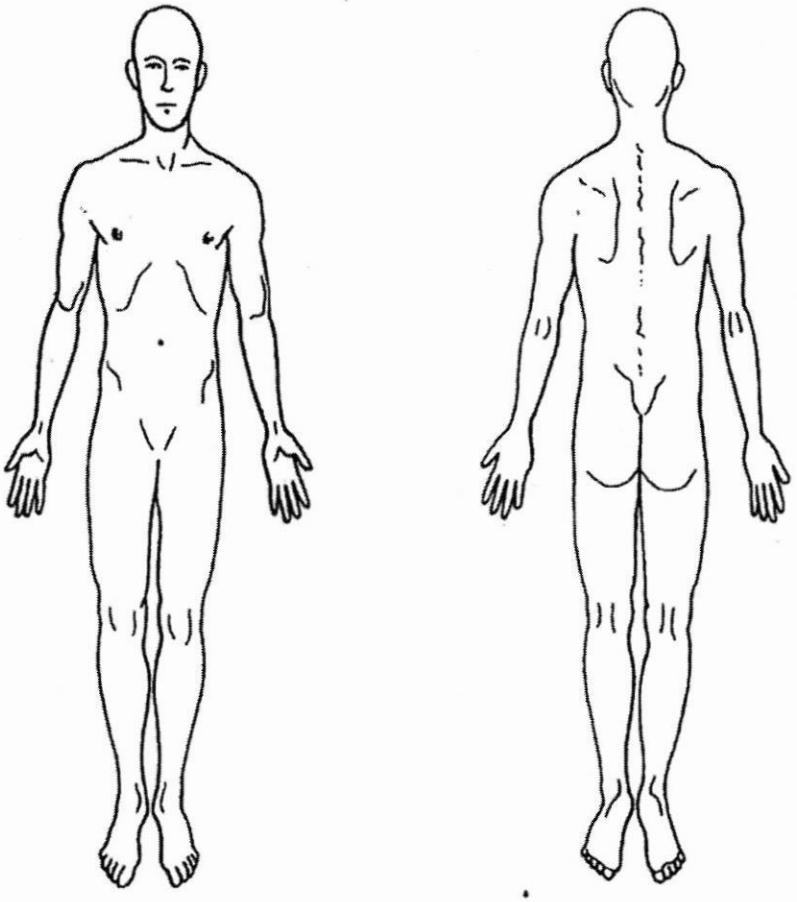
Numbness

Pins & Needles
ooooooo

Burning Pain
xxxxxxxxx

Stabbing Pain
//////////

Aching Pain
(((((((((



Chief Complaint:_____

Patient Explanation of Incident:_____

Date of Onset:_____ Did symptoms appear gradually or suddenly?_____
On the Job:____Yes____No Days off work:_____
Auto Accident:____Yes____No Days off work:_____

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Patient Name:_____ Date:_____

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	**Musculoskeletal**	Present
[ ]	Neck pain	[ ]
[ ]	Shoulder pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand pain	[ ]
[ ]	Upper back pain	[ ]
[ ]	Low back pain	[ ]
[ ]	Pain in upper leg or hip	[ ]
[ ]	Pain in lower leg or knee	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw pain	[ ]
[ ]	Swelling in joints (list joints)	[ ]
	_____	
[ ]	Stiffness of joints (list joints)	[ ]

Past	**Nervous System**	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bed wetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear pain	[ ]
[ ]	Impaired vision	[ ]
[ ]	Eye pain	[ ]
[ ]	Paralysis	[ ]

Past	**Cardiovascular**	Present
[ ]	Rapid heartbeat	[ ]
[ ]	Chest pains	[ ]

Past	**Endocrine**	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	Respiratory	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic pain	[ ]
[ ]	Chronic cough	[ ]
[ ]	Chronic sinusitis	[ ]

Past	**Gynecologic**	Present
[ ]	Pain during menstruation	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal symptoms	[ ]

Past	**Genito-Urinary**	Present
[ ]	Painful urination	[ ]
[ ]	Loss of bladder control	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	**GI Tract**	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	**Skin**	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Please check any of the following that apply to you.

[ ]	Tobacco
[ ]	Alcohol, Qty/Frequency
[ ]	Tranquilizers/Sedatives
[ ]	Laxatives
[ ]	Coffee, cups/day
[ ]	Regular soda, cans/day
[ ]	Diet soda, cans/day
[ ]	Water

Family History: Listed below are common diseases and disorders. Please indicate whether you have a Parent, Sibling, and/or Grandparent who have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	**Condition**	Present
[ ]		[ ]
[ ]	Heart disease	[ ]
[ ]	High blood pressure	[ ]
[ ]	Angina	[ ]
[ ]	Heart attack	[ ]
[ ]	Stroke	[ ]
[ ]	Asthma	[ ]
[ ]	Gallbladder	[ ]
[ ]	Cancer	[ ]
[ ]		[ ]

Past	**Condition**	Present
[ ]	Emphysema	[ ]
[ ]	Arthritis	[ ]
[ ]	Drug or alcohol dependency	[ ]
[ ]	Diabetes	[ ]
[ ]	Ulcer	[ ]
[ ]	Kidney stones	[ ]
[ ]		[ ]
[ ]	Other_____	[ ]
[ ]	Other_____	[ ]
[ ]	Other_____	[ ]

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