Dynamic Family Chiropractic

4739 Hwy 101 S. * Minnetonka, MN 55345* 952.933.2695 * Fax 952.933.2763

Patient Information

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( )_____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: _____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? ☐ Yes ☐ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

HEALTH CONDITIONS

CERVICAL SPINE (NECK):

Postural distortions from subluxations (misalignments of the spine) in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent colds/Flue
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ❑ Heart Problems
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness Of Breath
- ❑ Pain On Deep Inspiration/Expiration

THOPRACIC SPINE (MID BACK):

Postural distortions from subluxations in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Blood Sugar problems

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose : _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

GOALS FOR MY CARE

Indicate all statements that apply to you:

❑ I have a specific health concern which I would like relief from.

❑ I want to ensure that my health concerns do not become an ongoing problem.

❑ I am interested in learning more about how chiropractic can help my overall health.

Please indicate what services you are interested in:

❑ I am interested in chiropractic care.

❑ I am interested in nutritional consultation and supplementation.

❑ I am interested in back strengthening and exercise routines.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised the x-ray can be hazardous to an unborn child.

Date of the last menstrual cycle: _____

_____ Signature

_____ Date