PRECISION SPINAL CARE

Taylor Mainous
Doctor of Chiropractic

First Name: ____

Last Name: ____

Gender: *M / F* Date of Birth: ______________________ Age: ____

Email: ____

Address: _____________________________Zip: ___________City: __________State: ______

Phone Number: H: ( ) __________________ C: ( ) ___________________

Cellphone Provider: *Verizon/ AT&T/ Other:* _____________Receive Texts for Apt. Reminders? __

Employer: ____ Job Title: _______________________

Employer Phone # ( )_______________

Marital Status: Single Married Widowed Divorced Other: _________________

Spouse (Name) : ________________________________Phone # : _______________________

Emergency Contact Name: ______________________ Phone # :_________________________

How did you find our office: (Internet, fair booth, email, friend, family member, other)

Who may we thank for referring you? ____

What brings you into the office today? ____

Work Injury (Y/ N) Auto Accident (Y/ N) *if **Yes** to either please let receptionist know*

Onset Date: _________ Duration of Pain: ____

Have you had this before? (Yes/No)
Explain:____

Does the pain travel? (Y/N) If ***Yes,*** where? ____

Rate your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

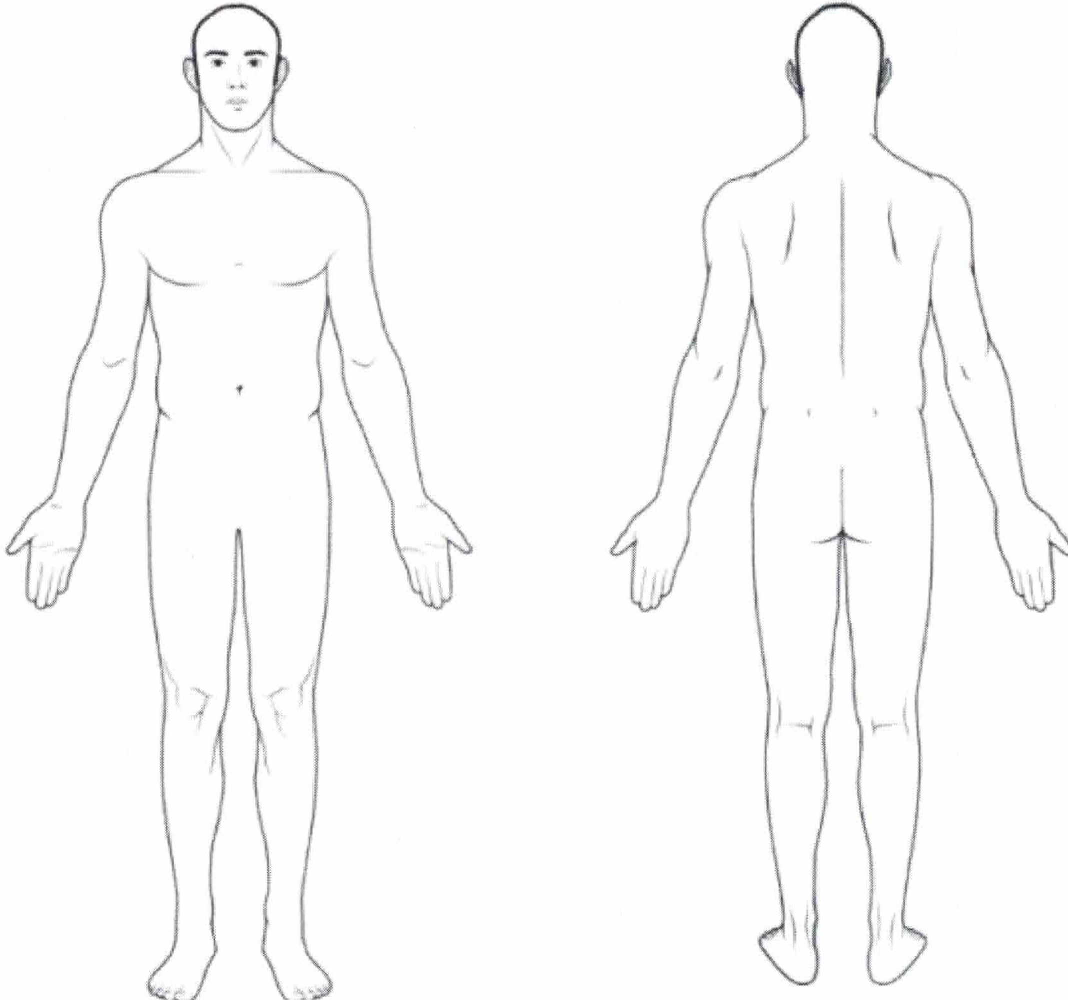
Frequency of pain: Constant Intermittent Occasional Rare

Since the start has it gotten: Better, Worse, Staying the same

Describe the pain: Dull Achy Tingling Shooting Sharp Hot Cold Tight Stiff Throbbing

Other health care providers seen for your symptoms? ____________________________

Mark the location of your symptoms with an "X" :



Past Health History:

Have you had any surgeries? (Yes / No)

______________________ Date: ________ ______________________ Date: ________

______________________ Date: ________ ______________________ Date: ________

______________________ Date: ________ ______________________ Date: ________

Have you had any major traumas? (Yes / No) *Please list…*______________________

____

Medications you are currently taking:______________________________________

____

____

Major Illnesses you have had: ____

Female Only: Are you currently pregnant? Yes / No If yes, due date: ____________________

Other symptoms you are experiencing: (Circle any that apply)

Headaches	Loss of appetite	Light sensitivity	Arm pains	Bed wetting
Neck pain	Depressed	Chest pain	Genital Pain	Shortness of Breath
Facial pain	Blurry vision	Hearing loss	Reproductive Issues	Cold Hands
Shoulder pain	Fogginess	Ear infections	Poor Circulation	Cold Feet
Pins and Needles(arms)	Disoriented	Upper Back Pain	Foot pain	Numbness
Pins and Needles (legs)	Loss of memory	Lower Back Pain	Wrist pain	Twitching
Fatigue	Balance issues	Pelvic Pain	Elbow pain	Hyper-activity
Dizziness	Ringing in ears	Leg pains	Fever	Hypo-activity

Family Health History

	Name/Age	Health Issues	Living/ Deceased
Mother			L / D
Father			L / D
Grandmother			L / D
Grandfather			L / D
Brother(s)			L / D
Sister(s)			L / D

Daily Activity

	Amount/Day	How Long (Duration)	Would you like to change?
Smoking			
Alcohol			
Coffee/Caffeine			
Tobacco			

Current Stress Level (circle one)

None Mild Moderate High Extreme

Financial Policy

I understand that should I default on a payment of my account and a collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court cost will be added to the balance of my account.

Signature: ____Date: _______________