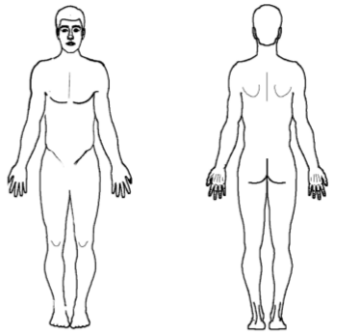
# Thacker Chiropractic Clinic

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____
Zip: _____ Telephone: (____)_____Cell: (_____)_____ SSN # _____
Occupation: _____ Employer: _____ Work: (_____)_____
E-mail: _____

**Describe your current problem and how it began:**

☐ Headache ☐ Neck Pain ☐ Mid-back pain ☐ Low back pain
Is this: ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began: _____
How Problem Began: _____

**Mark an X on the picture where you have pain**



**Current complaint (how you feel today)**

0 1 2 3 4 5 6 7 8 9 10
**No pain** **Unbearable pain**

How often are your symptoms present?
(Intermittent) ☐ 0 - 25% ☐ 26 - 50% ☐ 51 - 75% ☐ 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

**Have you had spinal X-rays, MRI, CT scan for your area(s) of complaint? ☐ No ☐ Yes**
**Please check all of the following that apply to you:**

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/ Fainting
☐ Numbness in Groin/ Buttocks
☐ Cancer/ Tumor (explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/ Seizures
☐ Other Health Problems (explain) _____
_____
_____
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at night
☐ Visual Disturbances
☐ Surgeries: _____
_____
_____
☐ Medications: _____
_____
_____

**Family History:** ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/ Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinic peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician if necessary.

**Patient Signature:** _____ Date: _____