**YOUNG CHIROPRACTIC**

**DR. BRAD YOUNG**

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**PATIENT INFORMATION**

Date_______________
Full Name____________________________________
Address_____________________________________
City_________________State____Zip___________
Phone#_____________Cell#___________________
Best Time to Reach You______________________
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed
Sex: ☐ M ☐ F Age___ Birthday_________________
Height__________ Weight_____________________
Patient SS#__________________________________
Occupation__________________________________
E-Mail Address_______________________________
Spouse's Name_______________________________
Occupation__________________________________
Whom may we thank for referring you?
____________________________________________

**INSURANCE**

Insurance Co.__________________________Plan_________
Address_____________________________________________
__________________________________Visit limit______
Phone #_____________________________________________
Name of Insured_____________________________________
Relationship to Patient_____________________________
Policy #____________________________________________
Insured SS#_________________DOB:__________Age____
SECONDARY INSURANCE
Insurance Co._______________________________________
Address_____________________________________________
____________________________________________________
Phone#______________________________________________
Name of Insured_____________________________________
Relationship to Patient_____________________________
Policy #____________________________________________
Insured SS#_________________DOB:_________Age____

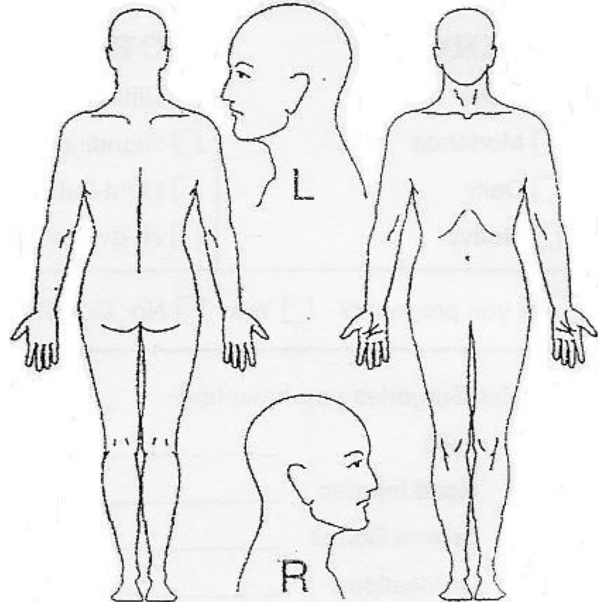
**IN CASE OF EMERGENCY, CONTACT:** Name_________________ Relationship____________

Present Complaint?__________________________________________________________________
When did your symptoms appear?______________________________________________________
Injury Cause? ☐ Auto ☐ Work ☐ Home ☐ Other__________________________________________
Have you had similar symptoms before?_________________________
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

**Circle areas of pain on picture and rate the severity of pain for each mark from 1 (least pain) to 10 (severe pain)**

***Mark areas on body:***

| | | |
|---|---|---|
| A = Ache | N = Numbness | SH = Shooting |
| B = Burning | P = Pinching | ST = Stabbing |
| D = Dull | S = Soreness | SP = Sharp |
| G = Grabbing | T = Tingling | TI = Tightness |
| | | TE = Tenderness |




***How often do you have this pain?***

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly:
If Daily, what percent: 10 20 30 40 50 60 70 80 90 100
Is the pain: ☐ constant ☐comes and goes

***Do symptoms interfere with:***

| | | | |
|---|---|---|---|
| ☐ Work | ☐ Sleep | ☐ Shopping | ☐ Dressing |
| ☐ Laundry | ☐ Driving | ☐ Eating | ☐ Bathing |
| ☐ Grooming | ☐ Talking | ☐ Self-Care/Hygiene | |
| ☐ Housekeeping | | ☐ Use of telephone | |
| ☐ Food Preparation | | ☐ Sexual Function | |

☐ Social/Recreational Activities (list) ______________________
_____________________________________________________

***Movements that are painful to perform & how long before pain starts?:***

☐ Sitting (How Long?) ___________ ☐ Standing (How Long?) ___________ ☐ Walking (How long?)_____________
☐ Bending Forward ☐ Bending Backward ☐ Bending Right ☐ Bending Left ☐ Lying Down ☐ Lifting ☐ Running
☐ Looking Up ☐ Looking Down ☐ Looking Right ☐ Looking Left

Have you been treated by a chiropractor before? ☐ Yes ☐ No How long ago?____________
Did the treatments help? ☐ Yes ☐ No