Steffen Chiropractic
6505 N. Prospect, Suite 700 Gladstone, MO 64119-1573
(816) 454-3399 Fax (816) 454-3012

PATIENT INFORMATION

Whom may we thank for referring you?________________ Date____________

Patient________________________ Age_____ Birthdate________ Sex *F or M* S.S.#__________

Address________________________ City____________________ State______ Zip__________

Single *Married* *Widowed* *Separated* *Divorced* Occupation________________

Phone Numbers Home________________ Cell________________ Texting: *Yes or No* Work__________

Email:____________________________

Spouse's Name________________________ Occupation________________________

Phone Number Cell________________ Texting: *Yes or No* Work__________

INCASE OF EMERGENCY, WHOM TO CONTACT

Name________________ Relationship____________ Phone________________

PATIENT CONDITION

Reason for Visit____

Is condition due to an accident? _____ If so what type of accident? *Auto* *Work* *Home* *Other*

To whom have you made a report of your accident? *Auto Insurance* *Employer* *Worker Comp.* *Attorney*

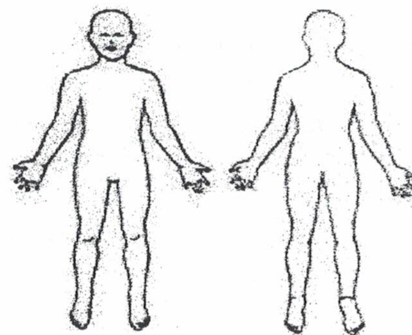
Name of Attorney (if applicable) ________________________

When did your symptoms appear? ________________________

Is this condition getting progressively worse? *Yes or No*

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____



Type of pain: *Sharp* *Dull* *Throbbing* *Numbness* *Aching* *Shooting* *Burning* *Tingling* *Cramps* *Stiffness* *Swelling* *Other*

How often do you have this pain? ________________________

Is it constant or does it come and go?________________________

Does it interfere with your *work* *sleep* *daily routine* *recreation*

Please list activities or movements that are painful to perform______________

Have you seen other doctors for your condition?_____ If so, when?_______ Did you receive x-rays or any scans?_______

Name and address of that doctor____

Are you pregnant? *Yes or No* Due Date________________

HEALTH HISTORY

PAST:

Family Diseases (list Father(F), Mother(M), Sister(S), Brother(B) and type of disease):

Arthritis:____Type:____________ Autoimmune Disease:____Type:____________Cancer:____Type:____________

Diabetes:_____Type:_____________ Heart Disease:______ Type:_____________ Stroke:____ Type:_____________

Other____

Please mark to indicate if you have had any of the following:

AIDS/HIV	*Alcoholism*	*Allergy Shots*	*Anemia*	*Anorexia*
Appendicitis	*Arthritis*	*Asthma*	*Bleeding Disorders*	*Breast Lump*
Bronchitis	*Bulimia*	*Cancer*	*Cataracts*	*Chemical Dependency*
Chicken Pox	*Diabetes*	*Emphysema*	*Epilepsy*	*Fractures*
Glaucoma	*Goiter*	*Gonorrhea*	*Gout*	*Headaches*
Heart Disease	*Hepatitis*	*Hernia*	*Herniated Disk*	*Herpes*
High Cholesterol	*Kidney Disease*	*Liver Disease*	*Measles*	*Migraines*
Miscarriage	*Mononucleosis*	*Multiple Sclerosis*	*Mumps*	*Osteoporosis*
Pacemaker	*Parkinson's*	*Pinched Nerve*	*Pneumonia*	*Polio*
Prostate Problems	*Prosthesis*	*Psychiatric Care*	*Rheumatoid Arthritis*	*Rheumatic Fever*
Scarlet Fever	*Stroke*	*Suicide Attempt*	*Thyroid Issues*	*Tonsillitis*
Tuberculosis	*Tumors/growths*	*Typhoid Fever*	*Ulcers*	*Vaginal Infections*
Venereal Disease	*Whooping Cough*	*other*______________________________		

PRESENT:

C. Allergies (Medication or other):

____

D. Medications & Vitamins (Name, dosages, & start date):

__________________ __________________ __________________ __________________

__________________ __________________ __________________ __________________

__________________ __________________ __________________ __________________

E. Surgeries (Type of procedure & When):

_________________________________ _________________________________

_________________________________ _________________________________

F. Lifestyle and Social Activities: Circle One for each item

Alcohol - *Daily Weekly Occasionally Never*

Caffeine Drinks and Products - *Daily Weekly Occasionally Never*

Exercise - *Daily Weekly Occasionally Never*

Tobacco - *Daily Weekly Occasionally Never*

Are you a Current smoker? *Yes or No* If no, are you a Former tobacco user? *Yes or No*

When did you quit? ______________________ How did you quit?______________________

Office Use Only

Height_______ Weight________ Blood Pressure________ Pulse_______ X-Ray #_________