TENNESSEE VALLEY CLINIC OF CHIROPRACTIC

304 FIRST AVE ❁ DAYTON, TN 37321 ❁ 423-775-6688 PHONE ❁ 423-775-8777 FAX

PLEASE PRINT

PERSONAL INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____CITY: _____

STATE: _____ ZIP: _____ E-MAIL: _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

GENDER: **MALE** **FEMALE** MARITAL STATUS: **S M D W** NUMBER OF CHILDREN: _____

REFERRED BY_____

EMPLOYER: _____OCCUPATION: _____ PHONE:_ _____

ADDRESS_____CITY: _____ STATE: _____ ZIP_____

NAME OF SPOUSE (OR PARENT)_____DATE OF BIRTH:_____

OCCUPATION/EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

MEDICARE? ___YES ___NO Primary Care Physician _____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT_____

HOW DID IT HAPPEN?_____

_____

TODAY'S CONDITION STARTED WHEN?_____

IS YOUR CONDITION DUE TO AN ACCIDENT? ___YES ___NO DATE OF ACCIDENT: _____

TYPE OF ACCIDENT? AUTO _____ WORK/ON JOB _____ AT HOME _____ OTHER _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION?_____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

ARE THERE ANY OTHER SYMPTOMS OR CONDITIONS YOU HAVE THAT MAY BE RELATED TO TODAY'S CONDITION?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

TYPE OF TREATMENT_____RESULTS_____

HOSPITALIZATIONS

DATE:	REASON:

MEDICAL HISTORY

1 = HAVE
2 = HAD
(*MARK BOX WITH **1** IF YOU HAVE THE SYMPTOM OR **2** IF YOU'VE HAD THE SYMPTOM IN THE PAST*)

__ABDOMINAL PAIN – CHRONIC	__FEVER	__PEPTIC ULCERS
__ANEMIA	__GALL BLADDER TROUBLE	__PERISTANT NAUSEA/VOMITING
__APPENDICITUS	__GLUTEN	__PNEMONIA
__ARTHRITIS/RHEUMATISM	__GOUT	__POOR CIRCULATION
__ASTHMA/WHEEZING	__HAYFEVER/ALLERGIES	__PROSTATE DISEASE
__BACK OR NECK PAIN – RECURRENT	__HEADACHES – FREQUENT	__PSORIASIS/ECZEMA
__BACK OR NECK STIFFNESS	__HEART MURMUR	__RAPID HEART BEAT
__BED-WETTING	__HEART PALPITATIONS	__RASHES/HIVES
__BELCHING OR GAS	__HEART/BLOOD VESSEL DISEASE	__RINGING IN EARS
__BLOATING	__HEMORRHOIDS	__SEXUAL/MENSTRUAL DYSFUNCTION
__BLOODY OR TARRY STOOLS	__HERNIA	__SHINGLES
__BLOOD IN URINE	__HIGH BLOOD PRESSURE	__SHORTNESS OF BREATH
__BONE FRACTURE/JOINT INJURY	__INDEGESTION OR HEARTBURN	__SINUS TROUBLE
__BRONCHITIS/CHRONIC COUGH	__INFECTIONS-FREQUENT	__SORE THROAT – FREQUENT
__BRUISE EASILY	__ITCHING/DRYNESS	__STROKE
__BURSITIS	__JAUNDICE/HEPATITIS	__SWEATS
__CANCER	__JOINT PAIN/STIFFNESS/SWELLING	__SWELLING
__CHANGE IN BOWEL HABITS	__KIDNEY STONES	__SWOLLEN ANKLES
__CHEST PAIN	__LACTOSE INTOLERANCE	__SWOLLEN TONSILS/GLANDS
__CHROHN'S/COLITIS	__LEG PAIN – WALKING	__THYROID DISEASE
__CHRONIC FATIGUE	__LOSS OF APPETITE	__TREMOR/HANDS SHAKING
__COLD/NUMB EXTREMITIES	__LOW BLOOD PRESSURE	__URETHRAL DISCHARGE
__CONSTIPATION	__LUPUS	__URINE INFECTION
__CONVULSIONS/SEIZURES	__MEMORY LOSS	__FREQUENTURINATION
__COPD	__MENTAL ILLNESS	__OVERNIGHT <TWICE
__DEAFNESS	__MOODINESS-EXCESSIVE	__PAINFUL
__DEPRESSION	__MULTIPLE SCLEROSIS	__LOSS OF CONTROL
__DIABETES	__MUSCLE WEAKNESS	__DECREASE IN FORCE/FLOW
__DIARRHEA	__NERVOUSNESS/ANXIETY	__VARICOSE VEINS
__DIFFICULT DIGESTION	__NEUROPATHY(BURNING IN FEET/HANDS)	__VENEREAL DISEASE
__DIFFICULTY SWALLOWING	__NOSE BLEEDS	__WEIGHT LOSS – RECENT
__DIVERTICULITIS/CROHNS/COLITIS	__NUMBNESS/TINGLING SENSATIONS	__WHOOPING COUGH
__DIZZINESS/BALANCE	__OSTEOPOROSIS	__OTHER_____
__EAR INFECTIONS	__PAIN GOING DOWN ARMS	__OTHER_____
__EYE INFECTIONS - FREQUENT	__PAIN GOING DOWN LEGS	
__EYE PAIN	__PHOBIAS	
__FAILING VISION	__PAINFUL TAIL BONE	
__FAINTING		

CONTINUE...
__DIPTHERIA
__TETANUS
__CHICKEN POX POLIO MUMPS
__MEASLES
__RUBELLA
__RHEUMATIC FEVER
__SCARLET FEVER
__TUBERCULOSIS
__HERPES
__OTHER_____
__OTHER_____

HABITS
__ ALCOHOL: TYPE _____ AMOUNT _____
__ SMOKING: PACKS DAILY _____ HOW LONG? _____
__INTERESTED IN STOPPING? _____
__ CAFFEINE: COFFEE, CUPS DAILY? _____ OTHER _____
__ EXERCISE ROUTINE (PLEASE EXPLAIN) _____
_____

SLEEP (*PLEASE CHECK ALL THAT APPLY*)
__ DIFFICULTY FALLING ASLEEP __CONTINUITY DISTURBANCES
__ EARLY MORNING AWAKENINGS __DAYTIME DROWSINESS
OTHER:_____

FEMALES- PLEASE COMPLETE
ARE YOU PREGNANT?❑YES ❑NO
PLANNING PREGNANCY? ❑YES ❑NO
MENSTRUAL FLOW ❑REGULAR ❑IRREGULAR ❑PAIN/CRAMPS ❑FLUSHING ❑MENOPAUSE
LENGTH OF CYCLE?_____
1ST DAY OF LAST PERIOD?_____
DO YOU EXPERIENCE PAIN/BLEEDING DURING OR AFTER INTERCOURSE?❑YES ❑NO
BIRTH CONTROL METHOD? (*LIST ANY MEDICATIONS*)_____
DATE OF LAST PAP TEST? _____ ❑ NORMAL ❑ ABNORMAL

NUMBER OF:
PREGNANCIES _____
ABORTIONS _____
MISCARRIAGES _____
LIVE BIRTHS _____