Cumberland Chiropractic and Sports Medicine
1633 W Main St, Suite 401 Lebanon, TN 37087 Phone (615) 444-2234 Fax (615) 547-4849 WWW.CUMBERLANDSPINE.COM

Confidential Patient Information

Patient's Full Name _____ Preferred Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Date of Birth: ____/____/_____ Age: _____ ☐ Male ☐ Female Social Security # _____ - _____ - _____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children/Ages _____

Occupation: _____ Hours/Week _____ Employer: _____ Business Phone _____

Spouse's Name: _____ Employer: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ City: _____ State: _____ Phone _____

May our office inform your family physician of presenting condition/s, exam findings, diagnosis, and treatment plan? ☐ Yes ☐ No

Previous Chiropractic Care: ☐ Yes ☐ No Dr's Name _____ City/State: _____

How did you hear about us? Friend, Relative, Physician….Their Name: _____ Other: _____

(**If yes to either question below, please see receptionist, additional info is needed**)

Is Today's Visit Due To An On the Job, Work Related Injury: ☐ Yes ☐ No **Date Of Injury:** _____
Is Today's Visit Due To An Auto Accident: ☐ Yes ☐ No

****In Order of Importance, List Your Pains/Problems****

Complaint #1: _____ Onset Date: _____

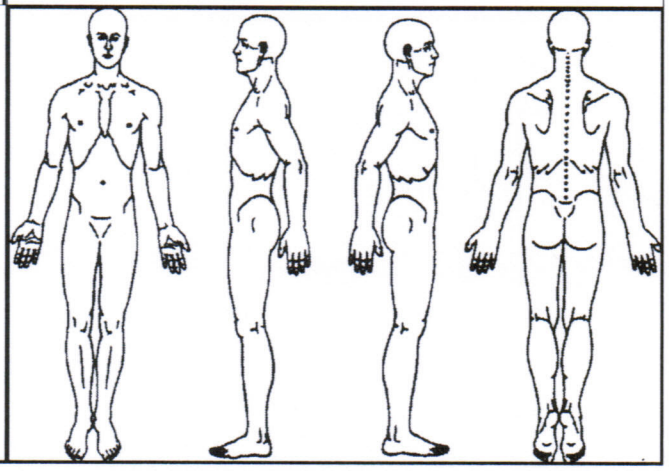
Severity: 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

Complaint #2: _____ Onset Date: _____

Severity: 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

Please Mark Your Pain on the Picture to the Right

****Mark Your Pains / Problems On The Picture****



How did your **Complaint #1** start? (ex. fell on ice) _____

What makes **it** worse? ☐ bending ☐ standing ☐ sitting ☐ walking Other: _____

What makes **it** better? ☐ laying down ☐ sitting ☐ standing ☐ walking Other: _____

What is its quality of **Complaint #1**? ☐ sharp ☐ dull/ache ☐ throbbing ☐ tingling/numbness/burning ☐ _____

When does it hurt the most? ☐ morning ☐ during day ☐ evening ☐ lying in bed ☐ Other: _____

How much of the day do you experience **it**? ☐ 0 — 25% ☐ 25 — 50% ☐ 50 — 75% ☐ 75 — 100%

Have you ever experienced **Complaint #1** before: ☐ Yes ☐ No If yes, When: _____
Was treatment provided: ☐ Yes ☐ No If yes, By whom: _____ Outcome: _____

How much have these **pains/problems** interfered with your day? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Significantly ☐ Extremely

Has your **pain/problems** resulted in any: ☐ Muscle Weakness ☐ Bowel/Bladder control ☐ Digestion Issues ☐ Heart/Breathing Issues

Have you tried ice, heat, stretches etc. or taken any medication (over the counter or prescription) for your **current pain/problems**: ☐ Yes ☐ No
If yes, explain: _____ Results: _____

What is your goal from treatment (e.g. play a round of golf without pain)? _____

I am interested in the following adjunct therapies in order to treat my pain. ☐ Massage Therapy ☐ Dry Needling

Cumberland Chiropractic and Sports Medicine Confidential Patient Information
1633 W Main St, Suite 401 Lebanon, TN 37087 Phone (615) 444-2234 Fax (615) 547-4849 WWW.CUMBERLANDSPINE.COM

Overall, your **General Health** is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: _____

Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No If yes, explain: _____

Recently (in the past 6 weeks) or currently, are you taking **anti-coagulants, blood thinners or an antibiotic**? ☐ Yes ☐ No

Have you **ever** had any **major illnesses, injuries, hospitalizations, or surgeries?** ☐ Yes ☐ No

Date	Major Injury/Fracture/Illness/Surgeries	Treatment	Results

Please List current **supplements or drugs** you **currently** take: _____

_____

_____

Systems Review Questions: place check marks by body areas or systems where you may have problems:

1. ____Eyes
2. ____Ears, Nose, Mouth, Throat
3. ____Heart
4. ____Lungs/ Breathing
5. ____Intestines/Bowels
6. ____Urinary
7. ____Muscles
8. ____Nerves
9. ____Joints/Bones
10. ____ Skin
11. ____Internal Organs
12. ____Blood
13. ____Allergies
14. ____Psychological/Emotional
15. ____Gynecological Menstrual/Breast
16. ____Prostate/Testicular/Penile

Please explain check marks: _____

_____

_____

I am interested in diet and lifestyle counseling to help with high blood pressure, gut issues, low energy, weight loss, pain, etc.
☐ **Yes** ☐ **No**

Recreational Activities/Hobbies: _____

Your education level: ☐ High School ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Yes	No		
☐	☐	Do you exercise? _____	Times per week
☐	☐	Use tobacco? Type_____	Packs/Cans per day (If you have quit, when did you quit?)_____
☐	☐	Consume alcohol?	How many drinks per week? _____
☐	☐	Have a healthy diet?	If no, explain: _____
☐	☐	Get adequate sleep?	If no, explain: _____
☐	☐	Is Work/School stressful to you?	If yes, explain: _____
☐	☐	Family life stressful to you?	If yes, explain: _____
☐	☐	Use recreational drugs?	If yes, explain: _____

FAMILY HISTORY AND HEALTH STATUS: list any hereditary diseases or major illnesses which affect your mother/father/sister/brother:

_____

_____

How do you sleep ☐ Back ☐ Side ☐ Stomach Do you use a pillow : ☐ Yes ☐ No

Do you wear orthotics or arch supports ☐ Yes ☐ No Do you have a latex allergy: ☐ Yes ☐ No

Females: Date of last gynecological and breast exam:_____

For X-Ray Purposes: Possible pregnancy? ☐ Yes ☐ No Date of last menstrual cycle: _____

I hereby state that all the information I have provided is complete and truthful and that I have fully disclosed my health history.

SIGNED: _____ Date:_____

Witnessed: _____ Date:_____