

Cumberland Chiropractic and Sports Medicine

1416 W Main St, Suite H

Lebanon, TN 37087

Phone (615) 444-2234

Confidential Patient Information

Fax (615) 547-4849

WWW.CUMBERLANDSPINE.COM

Date: ____/____/____ Patient's Full Name _____

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

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

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

☐ 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 ☐ NoDo You Have Health Insurance? ☐ Yes ☐ No If yes, Please present insurance card to Front Desk Staff.Previous Chiropractic Care: ☐ Yes ☐ No Dr's Name _____ City/State: _____

Where did you hear about us? Or Referred By (Friend, Relative, or Physician) : _____

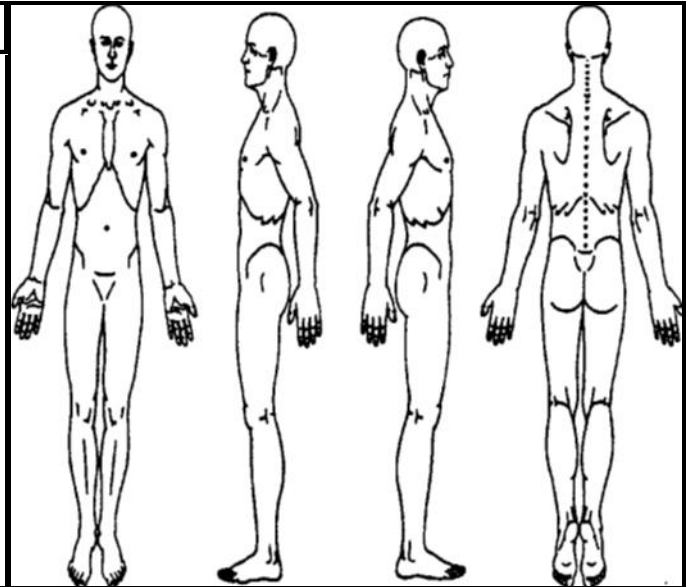
(**If yes to either question below, please see receptionist, additional info is needed**)

Is Today's Visit Due To An On the Job, Work Related Injury: ☐ Yes ☐ NoIs Today's Visit Due To An Auto Accident: ☐ Yes ☐ No Date Of Injury: _____***** Mark Your Areas of Pain on the Picture *******SEVERITY OF PAIN**

Chief Complaint: _____ Onset Date: _____

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

#2 Complaint: _____ Onset Date: _____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearableHow did your **Chief Complaint** start? (ex. fell on ice) _____What makes your pain worse? ☐ bending ☐ standing ☐ sitting ☐ walking Other: _____What makes your pain better? ☐ laying down ☐ sitting ☐ standing ☐ walking Other: _____What is the quality of your pain? ☐ sharp ☐ dull/ache ☐ throbbing ☐ tingling/numbness/burning ☐ Other: _____What is the worst time for your pain? ☐ morning ☐ during day ☐ evening ☐ lying in bed ☐ Other: _____How much of the day do you experience your chief complaint? ☐ 0 — 25% ☐ 25 — 50% ☐ 50 — 75% ☐ 75 — 100%Has your current complaint caused any of the following: ☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/RespiratoryHave you tried any self-treatment(ice, heat, exercises) or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain; _____ Results: _____

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

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WWW.CUMBERLANDSPINE.COMOverall your **General Health** is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ PoorHave you ever experienced your present problem before: ☐ Yes ☐ No If yes, When: _____Was treatment provided: ☐ Yes ☐ No If yes, By whom: _____ Outcome: _____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: _____Are you currently taking **anti-coagulant** or **blood thinning medication**? ☐ Yes ☐ NoHave you **ever** had any **major illnesses, injuries, hospitalizations, or surgeries**? ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Please List current **supplements or drugs** you may be taking: _____

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

- | | | | |
|----------------------------------|---------------------------|-------------------------|--|
| 1. ___ Eyes | 5. ___ Intestines/Blowels | 9. ___ Joints/Bones | 13. ___ Allergies |
| 2. ___ Ears, Nose, Mouth, Throat | 6. ___ Urinary | 10. ___ Skin | 14. ___ Psychological/Emotional |
| 3. ___ Heart | 7. ___ Muscles | 11. ___ Internal Organs | 15. ___ Gynecological Menstrual/Breast |
| 4. ___ Lungs/ Breathing | 8. ___ Nerves | 12. ___ Blood | 16. ___ Prostate/Testicular/Penile |

Please explain check marks: _____

Recreational Activities/Hobbies: _____**Your education level:** ☐ Highschool ☐ Some college ☐ 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 diseases or major illnesses which affect your family (mother/father/sister/brother): _____

How do you sleep ☐ Back ☐ Side ☐ Stomach Do you use a pillow : ☐ Yes ☐ NoDo you wear orthotics or arch supports ☐ 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: _____