Cumberland Chiropractic and Sports Medicine
1416 W Main St, Suite H Lebanon, TN 37087 Phone (615) 444-2234 Fax (615) 547-4849 WWW.CUMBERLANDSPINE.COM

Confidential Patient Information

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 ☐ No

Do You Have Health Insurance? ☐ Yes ☐ No If yes, Please present insurance card to Front Desk Staff.

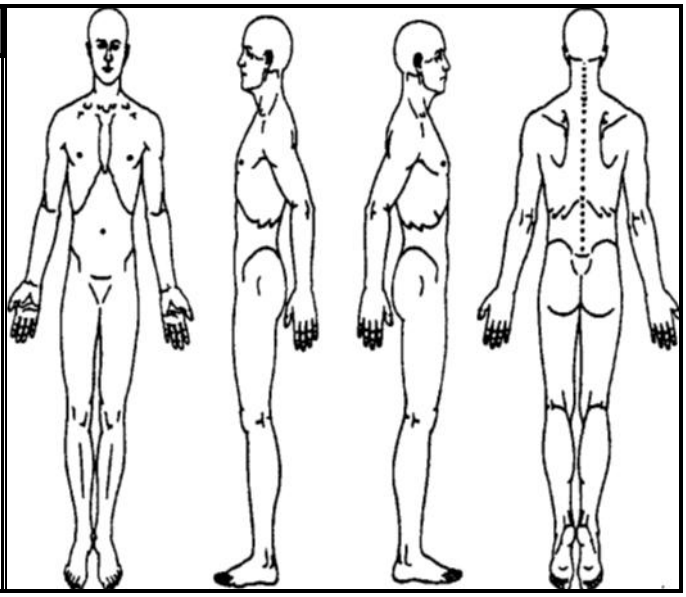
Previous Chiropractic Care: ☐ Yes ☐ No Dr's Name _____ City/State:_____

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 ☐ No
Is 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 unbearable

How 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/Respiratory

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

Have 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 ☐ No

Have 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/Bowels	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 ☐ No

Do 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:_____