BOSMAN
CHIROPRACTIC LIFE CENTER, P.C.

PATIENT INFORMATION

Date: _____

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS

Name (last name first)	Date of birth	Age	Social Security No.
			Telephone No.
Address	City	State	Zip / Email:

☐ Male ☐ Female	☐ Single ☐ Married	Name of Spouse	Health
No. of children	Names of children		Health
Occupation	Employer		Work phone no.

Briefly describe your problem:	Doctors seen for these problems (give names)
1.	1.
2.	2.
3.	3.
4.	4.

Treatment given for these problems (Examples: medicine, surgery, physical therapy)

Referred by	Have you had chiropractic care before? ☐ Yes Where? ☐ No	Name of health insurance co.?

Is it possible you are pregnant? ☐ Yes ☐ No	Are you on Medicare? ☐ Yes ☐ No	Are you on Medicaid? ☐ Yes ☐ No	Are you on a reimbursing insurance policy? ☐ Yes ☐ No Company Name:

Please indicate if you are here for care because of: ☐ an on the job injury ☐ an auto accident

Date injured	Insurance company	Attorney's name	Attorney's address

Have you ever had any falls, accidents or injuries?
☐ Yes Please describe.
☐ No

MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

Have you ever had surgery?
☐ Yes Please describe.
☐ No

MONTH, YEAR	TYPE OF SURGERY	WHY WAS SURGERY PERFORMED?

Are you presently taking medication?
☐ Yes Please list the name of the drug and tell why you are taking it.
☐ No

NAME OF DRUG	DOSES PER DAY	WHAT ARE YOU TAKING IT FOR?

PLEASE SEE OTHER SIDE

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD A PROBLEM WITH:

- ☐ Headaches
- ☐ Shooting head pain
- ☐ Head feels too heavy
- ☐ Twitching of face
- ☐ Sinus Trouble
- ☐ Dizziness
- ☐ Pain in ears ☐L ☐R
- ☐ Ringing in ears ☐L ☐R
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Neck pain
- ☐ Stiff neck
- ☐ Grating in neck
- ☐ Muscle spasms in neck
- ☐ Thyroid trouble
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Tightness of throat
- ☐ Difficulty breathing
- ☐ Chest pain
- ☐ Mid Back pain
- ☐ Shoulder pain ☐L ☐R
- ☐ Tightness in shoulders ☐L ☐R
- ☐ Arm pain ☐L ☐R
- ☐ Numbness in arms ☐L ☐R
- ☐ Elbow pain ☐L ☐R
- ☐ Wrist pain ☐L ☐R
- ☐ Cold hands ☐L ☐R
- ☐ Tingling in hands ☐L ☐R
- ☐ Numbness in hands ☐L ☐R
- ☐ Pain in side ☐L ☐R
- ☐ Rib pain ☐L ☐R
- ☐ Hip pain ☐L ☐R
- ☐ Low Back pain
- ☐ Pain in legs & feet ☐L ☐R
- ☐ Numbness in legs ☐L ☐R
- ☐ Cramps in legs ☐L ☐R
- ☐ Poor Circulation
- ☐ Sciatica ☐L ☐R
- ☐ Knee pain ☐L ☐R
- ☐ Ankle pain ☐L ☐R
- ☐ Nervousness
- ☐ Scoliosis
- ☐ Fatigue
- ☐ Irritability
- ☐ Sleeping trouble
- ☐ Arthritis
- ☐ Bursitis
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Ulcers
- ☐ Stomach pain
- ☐ Indigestion
- ☐ Constipation
- ☐ Colitis
- ☐ Urinary trouble
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Menstrual cramps
- ☐ Menstrual irregularity
- ☐ High Blood Pressure
- ☐ Diabetes

SECONDARY COMPLAINTS
(Doctors use only)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

☐ Daily visits for _____ weeks

ADJUSTING SCHEDULE ☐ 1 per 2 weeks ☐ 1 per month

Date _____ M T W Th F Sa Su

N F R

SPECIAL INSTRUCTIONS

X-RAY REPORT & SPINAL ANALYSIS

At	☐	1L	☐
Ax	☐	2	☐
3	☐	3	☐
4	☐	4	☐
5	☐	5	☐
6	☐		
7	☐		
1D	☐	**L. Ilium**	
2	☐	☐	Pl
3	☐	☐	As
4	☐	☐	In
5	☐	☐	Ex
6	☐		
7	☐	**R. Ilium**	
8	☐	☐	Pl
9	☐	☐	As
10	☐	☐	In
11	☐	☐	Ex
12	☐		

Osteophytic Changes

C	T	L
☐	☐	☐

Degeneration

C	T	L
☐	☐	☐

Loss of Lordotic Curve

C	L
☐	☐

Other: _____

DO NOT WRITE BELOW THIS LINE

	Subluxation	Corrective Tissue	Nerve Tissue	Bio Mechanical	Symptoms
1°					

DEFINITION:

	Subluxation	Corrective Tissue	Nerve Tissue	Bio Mechanical	Symptoms
2°					

DEFINITION:

	Subluxation	Corrective Tissue	Nerve Tissue	Bio Mechanical	Symptoms
3°					

DEFINITION:

	Subluxation	Corrective Tissue	Nerve Tissue	Bio Mechanical	Symptoms
4°					

DEFINITION:

SUBJECTIVE FINDINGS -

PAIN CLASSIFICATION	C	T	L
Minor	☐	☐	☐
Moderate	☐	☐	☐
Severe	☐	☐	☐

OBJECTIVE FINDINGS -

	Cervical L	Cervical R	Thoracic L	Thoracic R	Lumbar L	Lumbar R
☐ Muscle spasms	☐	☐	☐	☐	☐	☐
☐ Restricted ROM	☐		☐		☐	
☐ Fixations	☐		☐		☐	

Areas of Tenderness	L	R
Cervical		
Dorsal		
Lumbar		
Pelvic		

	L	R
Head tilt		
Shoulder high on		
Ilium high on		

ORTHOPEDIC TESTS

	L	R	B	N
☐ Anvil	☐	☐	☐	☐
☐ Lindner's	☐	☐	☐	☐
☐ Foraminal Compression	☐	☐	☐	☐
☐ Shoulder Depression	☐	☐	☐	☐
☐ Soto-Hall	☐	☐	☐	☐
☐ Kemp's	☐	☐	☐	☐
☐ Braggard's	☐	☐	☐	☐
☐ Fabre Patrick's	☐	☐	☐	☐
☐ Lasegue's ☐L___° ☐R___°	☐	☐	☐	☐

Height _____ Ambulatory ☐ Yes ☐ No

Weight _____ Analgia ☐L ☐R ☐None

Doctor _____