AMY FORTH, DC
(678) 449-5759

Patient Information

Name:_______________________________________ ***Date:*** ___________________
Address: _________________________ City: ___________ State: _____ Zip: ______________
Date of Birth: _________________ Age: _______ Sex: M F Height:_______ Weight_______
Home phone: _________________ Work phone:______________ Cell phone: _________________
E-Mail:_______________________Employer/Occupation:___________________________________
Marital Status: S M D W Spouse's Name:_________________ Social Security #:_______________
Primary Care Physician (name, address, telephone):____
How did you hear about us?____

Chief Complaint: Describe the major complaint that brought you to this office:_________________
____

When did it start?______________________ Have you ever had this problem before? ____________
Have you seen any other doctors for this condition? Yes No Who? ___________________________

What makes your symptoms better? Rest Motion Heat Ice Sitting Lying Other _________

What makes your symptoms worse? Standing Sitting Lying Motion Rest Bending Reaching
Coughing Sneezing Lifting Walking Other____________________

Describe your pain: Dull Knifelike Burning Numb Soreness Stiffness Stabbing Sharp
Throbbing Other____________________

Does it radiate to any other area of the body? Y N Where?__________________________________

How would you describe the intensity? Mild Moderate Severe

Since the onset, is the pain: Constant Off & On Worse Better The same

Do you feel worse: In the morning In the evening Always the same

Symptoms developed from: Work-related injury Y N Auto Accident Y N Injury at home Y N
Did it begin gradually or suddenly? Gradual Sudden

What tests have been done for your condition?____
Any X-rays in the last 2 years? Y N What area was x-rayed?_________________________________

Have you been unable to work as a result of your current problem?______________________________

General Information:

Amt of sleep per night (hours): ______ Position in which you typically sleep____________________
Is your sleep: Great Good Fair Poor

Are you taking any medications? (Please list) ____

Past history

Are you under a doctor's care presently for any type of health problem?_________________________

Have you had any broken bones? Y N Which ones? _____________________________________

Have you ever had any past significant auto accidents, work injuries or falls? Y N When?__________

Have you ever had surgery? Y N What and When? ____
____

Do you now or have you ever smoked, used alcohol or recreational drugs?______________________

Do you have any allergies? ____

Have you been diagnosed with:

Y N High Blood Pressure
Y N Hardening of the arteries
Y N Diabetes
Y N Heart or blood vessel disease
Y N Bone spurs on the neck
Y N Whiplash injury
Y N Fibromyalgia
Y N Chronic Fatigue
Y N Arthritis
Y N Cancer
Type?______________________

Women Only

Y N Do you take birth control pills?
How long? _______________
Y N Menstrual pain
Y N Irregularity
Y N Hot Flashes
Y N Night Sweats

Men Only:

Y N Difficulty with urination
Y N Excessive urination

Musculoskeletal

Neck	**Shoulders**	**Arms & Hands**
( ) Pain in the neck	( ) Pain in the shoulders (L R)	( ) Pain in upper arm
( ) Neck pain with movement	( ) Pain between shoulders	( ) Pain in lower arm
( ) Stiff Neck	( ) Tension in shoulders	( ) Pain in wrist/hand/finger
( ) Muscle spasms	( ) Pain with movement (L R)	( ) Numbness or tingling in hands
Low Back	**Hips, Legs and Feet**	
( ) Low back pain	( ) Hip Pain	( ) Knee pain
( ) Sciatica	( ) Pain down the leg	( ) Foot pain
( ) Muscle spasms	( ) Numbness or tingling	( ) Numbness or tingling in feet
( ) Stiffness	( ) Leg Cramps	( ) Heel pain

On a scale of 1- 10 (1= None 10= Extreme) Rate the following:

________Personal stress _______Occupational stress _______Home stress

How much exercise and what types of exercise do you get each week?______________________

How much water do you drink daily?____

Are you a vegetarian? Yes No Please describe your diet and indicate whether you are on a special diet____

I hereby certify to the best of my knowledge that the information given above is complete and correct

Patient signature ____Date_______________

Parent/Guardian signature ____Date_______________