DR. JAMES B. YOUNG

PATIENT INFORMATION | **INSURANCE**

Date_____
Full Name_____
Address_____
City_____State____Zip_____
Phone#_____
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed
Sex: ☐ M ☐ F Age___ Birthday_____
Height_____ Weight_____
Occupation_____
E-Mail Address_____
Spouse's Name_____
Occupation_____
Whom may we thank for referring you?
_____

Insurance Co._____Plan_____
Address_____
_____Visit limit_____
Phone #_____
Name of Insured_____
Relationship to Patient_____
Policy #_____
Insured SS#_____DOB:_____Age____
SECONDARY INSURANCE
Insurance Co._____
Address_____
_____
Phone#_____
Name of Insured_____
Relationship to Patient_____
Policy #_____
Insured SS#_____DOB:_____Age____

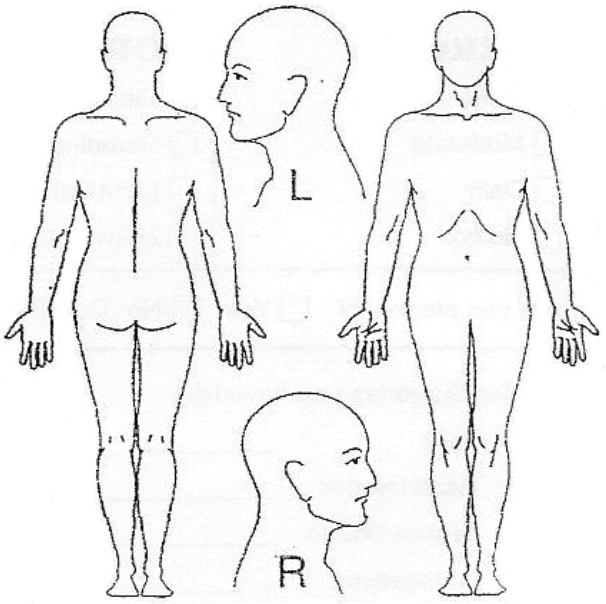
EMERGENCY CONTACT: Name_____ Relationship_____Number_____

Present Complaint?_____
When did your symptoms appear?_____
Injury Cause? ☐ Auto ☐ Work ☐ Home ☐ Other_____
Have you had similar symptoms before?_____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Circle areas of pain on picture and rate the severity of pain for each mark from 1 (least pain) to 10 (severe pain)

Mark areas on body:

A = Ache	N = Numbness	SH = Shooting
B = Burning	P = Pinching	ST = Stabbing
D = Dull	S = Soreness	SP = Sharp
G = Grabbing	T = Tingling	TI = Tightness
		TE = Tenderness



How often do you have this pain?
☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly:
If Daily, what percent: 10 20 30 40 50 60 70 80 90 100
Is the pain: ☐ constant ☐comes and goes

Do symptoms interfere with:

☐ Work	☐ Sleep	☐ Shopping	☐ Dressing
☐ Laundry	☐ Driving	☐ Eating	☐ Bathing
☐ Grooming	☐ Talking	☐ Self-Care/Hygiene	
☐ Housekeeping		☐ Use of telephone	
☐ Food Preparation		☐ Sexual Function	

☐ Social/Recreational Activities (list) _____
_____

Movements that are painful to perform & how long before pain starts?:
☐ Sitting (How Long?) _____ ☐ Standing (How Long?) _____ ☐ Walking (How long?)_____
☐ Bending Forward ☐ Bending Backward ☐ Bending Right ☐ Bending Left ☐ Lying Down ☐ Lifting ☐ Running
☐ Looking Up ☐ Looking Down ☐ Looking Right ☐ Looking Left

Have you been treated by a chiropractor before? ☐ Yes ☐ No How long ago?_____
Did the treatments help? ☐ Yes ☐ No

(Check if apply): □ dizziness/vertigo □ nausea/vomiting □ lack of balance □ trouble speaking □ double vision
□ vision loss □ Numbness on one side of face or body □ drop attacks - sudden numbness/weakness of face/arm/leg
□ dizziness/vertigo with neck rotation and/or extension □ negative response to being adjustment
□ bowel or bladder changes □ sudden onset of severe headaches/neck pain (different than ever before)

□ Pregnancy, # of births___ Due date_____

□ Past history of cancer □ Unexplained weight loss □ Pain improves with rest □ Corticosteroid use
□ Intravenous drug use □ Current/recent infection □ Current/recent urinary, respiratory infection
□ Immunosuppression medication &/or condition

□ History of significant trauma □ Osteoporosis □ Minor trauma and older than 50 years □ Are you over 70 years old
□ History of prolonged use of corticosteroids

□ Have you had or have urinary retention or overflow incontinence (wet underwear)
□ Loss of anal sphincter tone or fecal incontinence (bowel accidents)
□ Saddle anesthesia (numbness in the groin region)
□ Global or progressive muscle weakness in the legs (legs give out)

EXERCISE: □ None □ Moderate □ Daily □ Heavy
WORK ACTIVITY: □ Sitting □ Standing □ Light Labor □ Heavy Labor
HABITS: □ Smoking: Pack/Day _____ □ Alcohol: Drinks/Week _____ □ Coffee: Cups/Day _____
□ Caffeine Drinks: Oz/Day _____ □ Water: Oz/Day _____ □ High Stress Level: Reason _____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

□ Multiple sclerosis	□ Diphtheria	□ Pneumonia	□ Influenza	□ Goiter	□ Mumps	□ Gout
□ Venereal disease	□ Heart Disease	□ Scarlet fever	□ Cancer	□ Malaria	□ Anemia	□ Polio
□ Appendicitis	□ Tuberculosis	□ Emphysema	□ Pleurisy	□ Stroke	□ Eczema	
□ Arteriosclerosis	□ Typhoid fever	□ Alcoholism	□ Diabetes	□ Epilepsy	□ Ulcers	

List surgical operations and years: _____
_____

Drugs you now take: □ Nerve pills □ Pain killers □ Muscle relaxers □ "Pep" pills □ Tranquillizers □ Birth Control
Others:_____

Age of Mattress: _____ □ Comfortable □ Uncomfortable □ Do you use a bed board?

Are you wearing: □ Heel lifts □ Sole lifts □ Inner soles □ Arch supports

Have you been in an auto accident: □ Past year □ Past five years □ Over five years □ Never
Describe:_____

Have you ever had any mental or emotional disorders? □ No □ Yes, When?_____
Have others in your family had such disorders? □ No □ Yes, When?_____

Have you ever:	YES	NO	Describe Briefly
Been knocked unconscious?	□	□	_____
Used a cane, crutch, or other support?	□	□	_____
Been treated for a spine or nerve disorder	□	□	_____
Had a fractured bone?	□	□	_____
Been hospitalized?	□	□	_____
Do you take vitamins or minerals?	□	□	_____