

FORTIER CHIROPRACTIC HEALTH CARE

“Life Without Limits”

Dr. Seth A. Fortier • 220 Ellsworth St. SW • Albany, OR 97321 • Ph.(541)926-0510 • Fax(541)926-5540

CONFIDENTIAL PATIENT DATA

Name: _____ Date of Birth: _____ Date: _____

PLEASE LIST PRESENT MAJOR COMPLAINTS:

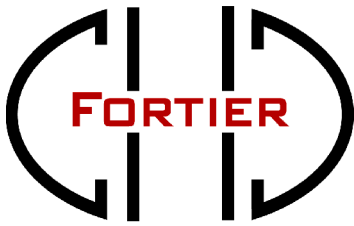
1. _____
2. _____

Please List ALL prescription medication you are taking and WHY: _____

How long have you had this condition?	Is it getting worse? Y / N
What was the initial cause?	
Does it bother you: work / sleep / other (please specify)	
Symptoms: <input type="checkbox"/> come and go <input type="checkbox"/> came on gradually <input type="checkbox"/> came on suddenly (date)	
Symptoms are: <input type="checkbox"/> worse in AM <input type="checkbox"/> worse in PM	
Have you ever had these symptoms before: Y / N	If yes, when?
What activities make symptoms worse?	
What activities make symptoms better?	
Symptoms feel like: <input type="checkbox"/> Deep/dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stiffness <input type="checkbox"/> Shooting <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Cramps <input type="checkbox"/> Swelling <input type="checkbox"/> Catching/locking <input type="checkbox"/> Popping/clicking <input type="checkbox"/> Electrical	
Have you seen a Chiropractor before? Y / N	If yes, when?
Name of primary care physician:	
Date of last physical exam:	Date of last physician visit: Reason:
(Women) Are you pregnant? Y / N Nursing? Y / N Taking birth control? Y / N	
Most of your day is spent: <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> walking <input type="checkbox"/> other (specify)	

Please check any ADDITIONAL symptoms you may be experiencing

- | | | | | |
|---|--|---|---|---------------------------------------|
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> cold feet | <input type="checkbox"/> concentration loss/confusion | <input type="checkbox"/> stiff neck |
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> dizziness | <input type="checkbox"/> face flushed | <input type="checkbox"/> ears ringing |
| <input type="checkbox"/> headaches | <input type="checkbox"/> insomnia | <input type="checkbox"/> light bothers eyes | <input type="checkbox"/> loss of balance | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> muscle jerking | <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> numbness in toes | <input type="checkbox"/> pins/needles in arms | <input type="checkbox"/> tension |
| <input type="checkbox"/> pins/needles in legs | <input type="checkbox"/> loss of smell | <input type="checkbox"/> loss of taste | <input type="checkbox"/> fainting | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> stiff neck | <input type="checkbox"/> stomach upset | <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> depression |
| <input type="checkbox"/> cold hands | <input type="checkbox"/> cold sweats | <input type="checkbox"/> fever (last 3 mo.) | <input type="checkbox"/> loss of memory | <input type="checkbox"/> fatigue |

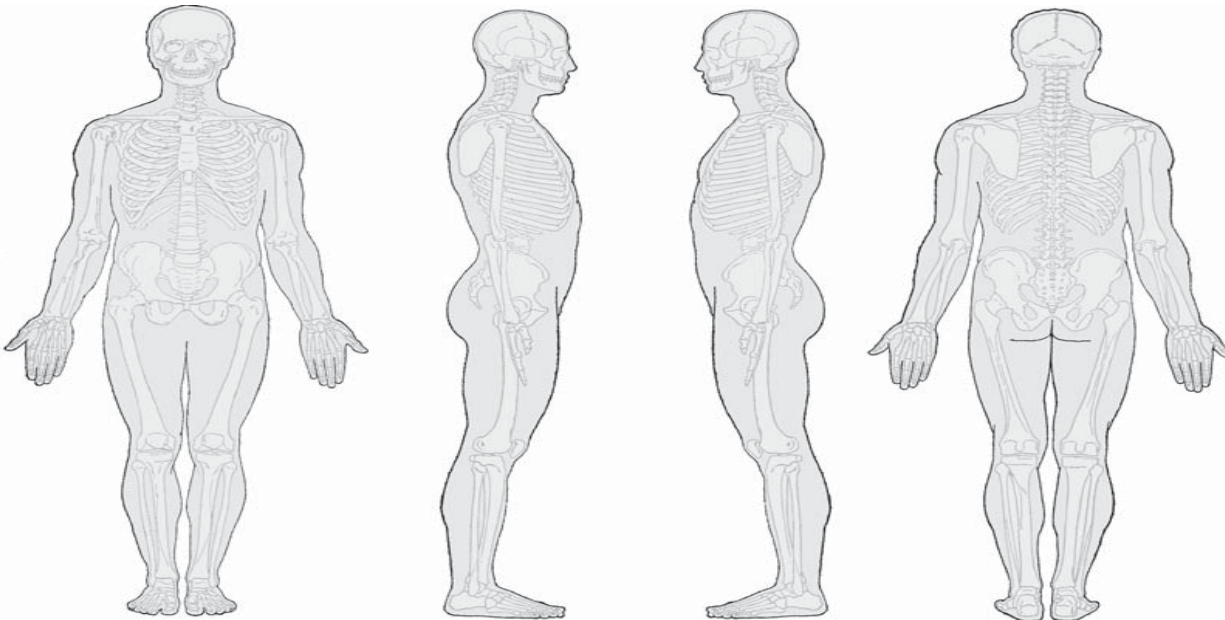


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Please mark the area(s) of your symptoms/pain on the figure below



Please Rate Your Pain/Discomfort:

0 ----- 5 ----- 10
 (No pain/discomfort) (Mild pain/discomfort) (Severe pain/discomfort)

Habits	None	Light	Mod.	Heavy
- Alcohol				
- Coffee				
- Tobacco				
- Exercise				
- Sleep				
- Sugar				

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS