

# ENTRANCE RECORD

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ S/S# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

# of Children \_\_\_\_\_ Ages \_\_\_\_\_

Driver's License # \_\_\_\_\_ Who may we contact in case of emergency? \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

If patient is a minor who is financially responsible for the bill? (Name/Address) \_\_\_\_\_

## PATIENT CHIEF COMPLAINT

Why are you here? Describe complaints / Symptoms / Injuries (Be as specific as you can in the space provided below:)

Involving Head and Neck: \_\_\_\_\_

Involving Mid-back/Shoulders/Arms & Hands: \_\_\_\_\_

Involving Low Back / Hips / Legs & Feet: \_\_\_\_\_

How and When it happened \_\_\_\_\_

Complaints/Symptoms ( ) Came on gradually ( ) Came on suddenly ( ) Are constant ( ) Come and Go / how often \_\_\_\_\_

Symptoms have persisted \_\_\_\_\_ hours \_\_\_\_\_ 1 day \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

What activities make condition **BETTER?** \_\_\_\_\_ **WORSE?** \_\_\_\_\_

Are symptoms **BETTER** in: ( ) AM ( ) Midday ( ) PM? **WORSE** in: ( ) AM ( ) Midday ( ) PM?

**PAIN LEVEL:** 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
No pain low pain moderate pain intense excruciating Is it getting \_\_\_\_\_ better or \_\_\_\_\_ worse?

Indicate your ability to perform the following activities: U = Unable D = Difficult P = Painful

- |   |                                    |  |   |  |
|---|------------------------------------|--|---|--|
| <input type="checkbox"/> Coughing or sneezing | <input type="checkbox"/> Climbing  | <input type="checkbox"/> Getting in or out of a car    | <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Kneeling            |
| <input type="checkbox"/> Turning over in bed  | <input type="checkbox"/> Balancing | <input type="checkbox"/> Walking short distances       | <input type="checkbox"/> Dressing self                  | <input type="checkbox"/> Standing for 1 hour |
| <input type="checkbox"/> Sleeping             | <input type="checkbox"/> Sitting   | <input type="checkbox"/> Lying on back                 | <input type="checkbox"/> Stooping                       | <input type="checkbox"/> Gripping            |
| <input type="checkbox"/> Lying on stomach     | <input type="checkbox"/> Pushing   | <input type="checkbox"/> Lying on side with knees bent | <input type="checkbox"/> Reaching                       | <input type="checkbox"/> Sexual activity     |
| <input type="checkbox"/> Bending over         | <input type="checkbox"/> Pulling   | <input type="checkbox"/> Climbing stairs               | <input type="checkbox"/> Lifting                        |  |

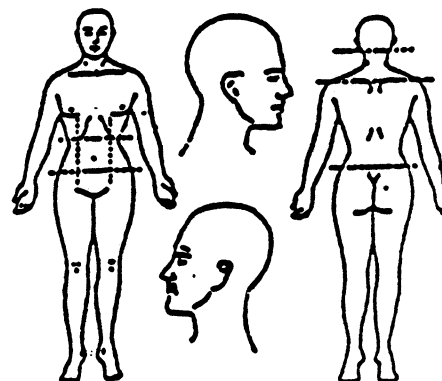
Mark areas to indicate location of pain or discomfort on drawing to the right.

Use: P = Pain N = Numbness  
S = Spasm T = Tenderness

Family History of:	Scoliosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
	Back Problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
	Heart Problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
	Arthritis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
	Osteoporosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father

(WOMEN ONLY) Are you pregnant? ( ) yes ( ) no  
Date of onset of last menstrual cycle \_\_\_\_\_

R L L R



**PLEASE COMPLETE OTHER SIDE**

# PATIENT HISTORY

Have you had this complaint / injury before? ( ) yes ( ) no If yes, when? \_\_\_\_\_

What treatment was received?(and by whom?) \_\_\_\_\_

Past surgeries or hospitalizations \_\_\_\_\_

Past Falls, Accidents, Fractures injuries \_\_\_\_\_

Date of last Physical Exam \_\_\_\_\_ Xrays \_\_\_\_\_

Current Medical Physician \_\_\_\_\_

Previous Chiropractic Care? yes \_\_\_\_\_ no \_\_\_\_\_ Date of last treatment? \_\_\_\_\_ Results? \_\_\_\_\_

Name of Doctor / Clinic and location? \_\_\_\_\_

Do you exercise (type and frequency)? \_\_\_\_\_

Circle if you use: Caffeine Alcohol Tobacco Vitamins (which) \_\_\_\_\_

Prescription/Over the Counter Drugs (name them) \_\_\_\_\_

Describe your general dietary habits \_\_\_\_\_

PLEASE **CHECK** SYMPTOMS YOU HAVE HAD PREVIOUSLY AND **CIRCLE** SYMPTOMS YOU NOW HAVE

**GENERAL SYMPTOMS**

- Headaches
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Loss of Weight
- Numbness or Pain in Arms, hands, legs
- Allergy
- Wheezing
- Neuralgia

**SKIN**

- Skin Eruptions
- Itching
- Bruising
- Dryness
- Boils
- Varicose Veins
- Sensitive Skin
- Hives or Allergy

**RESPIRATORY**

- Chronic Cough
- Spitting up phlegm
- Spitting up blood
- Chest pains
- Difficulty breathing

**EENT**

- Failing Vision
- Near-Sightedness
- Far-Sightedness
- Crossed Eyes
- Eye Pains
- Deafness
- Earache
- Ear Noises
- Ear Discharge
- Nose Bleeds
- Nasal Obstructions
- Sore Throat
- Hoarseness
- Hay Fever
- Asthma
- Dental Decay
- Gum Trouble
- Frequent Colds
- Enlarged Thyroid
- Tonsillitis
- Sinus Infection
- Nasal Drainage
- Enlarged Glands

**GENITOURINARY**

- Frequent Urination
- Painful Urination
- Bloody Urination
- Pus in Urine
- Kidney Infection/Stones
- Bed Wetting
- Inability to Control Urine
- Prostate Trouble

**CARDIOVASCULAR**

- Rapidly beating heart
- Slowly beating heart
- High blood pressure
- Low Blood Pressure
- Pain Over Heart
- Previous Stroke
- Hardening of Arteries
- Swelling of Ankles
- Poor Circulation
- Paralytic Stroke

**MUSCLE AND JOINT**

- Stiff neck
- Back Ache
- Swollen Joints
- Tremors
- Foot Trouble
- Painful Tail bone
- Pain Between Shoulders
- Hernia
- Spinal Curvature
- Faulty Posture

**WOMEN ONLY**

- Painful Periods
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Cramps or Backache
- Previous Miscarriage
- Vaginal Discharge
- Congested Breast
- Lumps in Breast
- Menopausal Symptoms

**GASTROINTESTINAL**

- Poor Appetite
- Difficult Digestion
- Excessive Hunger
- Belching of Gas
- Nausea
- Vomiting
- Vomiting blood
- Pain Over Stomach
- Distension of Abdomen
- Constipation
- Diarrhea
- Colon Trouble
- Hemorrhoids (Piles)
- Liver Trouble
- Gall Bladder Trouble
- Jaundice
- Colitis

**MEDICAL HX**

- Appendicitis
- Scarlet Fever
- Diphtheria
- Typhoid Fever
- Pneumonia
- Rheumatic Fever
- Polio
- Malaria
- Cancer
- Tuberculosis
- Whooping Cough
- Anemia
- Measles
- Mumps
- Small Pox

- Chicken Pox
- Diabetes
- Heart Disease
- Goiter
- Influenza
- Pleurisy
- Alcoholism
- Arthritis
- Epilepsy
- Venereal Infection
- Chorea
- Lumbago
- Eczema
- Mental Disorder

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Fees are payable at the time services are rendered unless other arrangements are made in advance. (IF MINOR) I authorize Dr. Stansberry & Associates to administer treatment as they so deem necessary to my son/daughter: \_\_\_\_\_ All of the above information is true and correct.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_