

Dr. Ronald E. Adams DC  
CONFIDENTIAL PATIENT INFORMATION  
(Please Print)

Date: \_\_\_\_\_ E-mail Address \_\_\_\_\_

Full Name: \_\_\_\_\_

Name of Wife, Husband or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Cell Phone Number ( ) \_\_\_\_\_

Social Security No. -- -- \_\_\_\_\_

Birthdate: \_\_\_\_\_ No. of Children \_\_\_\_\_ Currently Pregnant? \_\_\_\_\_

Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ Student: No \_\_\_ Part time \_\_\_ Full time \_\_\_

Occupation: \_\_\_\_\_

Employer's Name / Phone # : \_\_\_\_\_

Spouse's Occupation / Employer: \_\_\_\_\_

Name and phone # of Emergency Contact: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

List Chiropractors you have seen before:

1. Name: \_\_\_\_\_ When visited: \_\_\_\_\_

2. Name: \_\_\_\_\_ When visited: \_\_\_\_\_

List Medical Doctors consulted within the past year:

1. Name: \_\_\_\_\_ Reason for visit? \_\_\_\_\_

2. Name: \_\_\_\_\_ Reason for visit? \_\_\_\_\_

Please list all your reasons for visiting our office:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

List **ALL** medications you take. (Prescriptions and over-the-counter – use additional pages if needed)

Drug name: \_\_\_\_\_ Dosage: \_\_\_\_\_ How long have you taken this and for what condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List **ALL** nutritional supplements you take. (Use additional pages if needed)

Name of Supplements: \_\_\_\_\_ Dosage: \_\_\_\_\_ How long have you taken this and for what condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List **ALL** previous hospitalizations, surgeries, accidents, fractures and illnesses. (use additional pages)

(Example: **All past** Auto, Sports, Work, Home related).

1. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

Patient Name: \_\_\_\_\_

Check **ALL** "body signals" (symptoms/pain) you may have had or do have now:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> ADD/ADHD           | <input type="checkbox"/> Depression        | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Miscarriage          |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Allergy            | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Neck pain            |
| <input type="checkbox"/> Alzheimer's        | <input type="checkbox"/> Eczema            | <input type="checkbox"/> High Blood Sugar         | <input type="checkbox"/> Parkinson's Disease  |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Irregular Periods/Cramps | <input type="checkbox"/> Raynaud's            |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Irritable Bowel          | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Gall Bladder      | <input type="checkbox"/> Kidney infections/stones | <input type="checkbox"/> Ringing in Ears      |
| <input type="checkbox"/> Back pain          | <input type="checkbox"/> Goiter            | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Sinus infections     |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Gout              | <input type="checkbox"/> Low Blood Sugar          | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Celiac/Gluten Dis. | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Lyme Disease             | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Migraine                 | <input type="checkbox"/> Vertigo/dizziness    |

Please Check all of the following conditions your family has experienced.

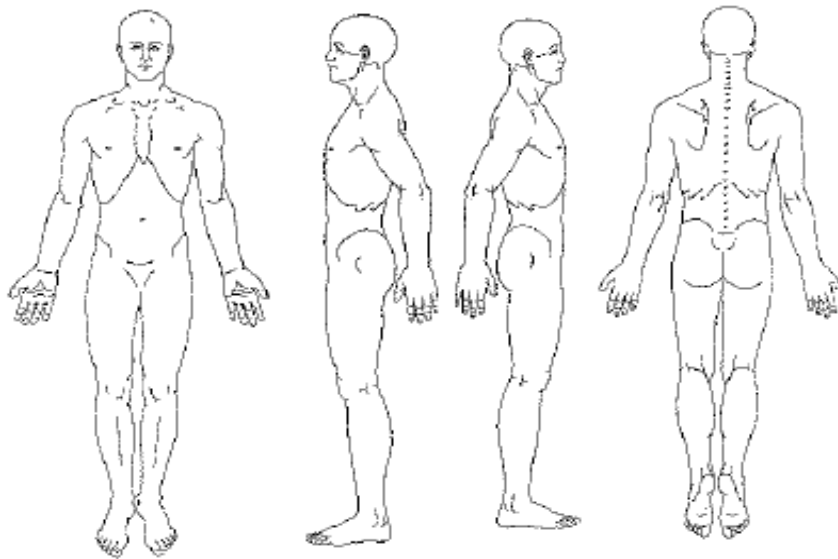
- |                  |                                      |                                 |                                   |  |                                      |                             |                                 |
|------------------|--------------------------------------|---------------------------------|-----------------------------------|--|--------------------------------------|-----------------------------|---------------------------------|
| Mother:          | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Father:          | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Grandmother (M): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Grandfather (M): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Grandmother (P): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Grandfather (P): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Sisters:         | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Brothers:        | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |

List any other health conditions that you or your family have had that are not listed: \_\_\_\_\_

Do you consume any of the following? (Leave blank what doesn't apply)

- Tobacco products (packs/day) \_\_\_\_\_ How many years? \_\_\_\_\_ Alcohol drinks/day \_\_\_\_\_ How many years? \_\_\_\_\_  
 Coffee/Tea cups/day \_\_\_\_\_ regular or decaf? \_\_\_\_\_ Soft Drinks # day \_\_\_\_\_ Regular or diet? \_\_\_\_\_  
 Do you use artificial sweeteners? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes please list? \_\_\_\_\_

Level of exercise? \_\_\_\_\_ None \_\_\_\_\_ Moderate (days per week) \_\_\_\_\_ Strenuous (days per week) \_\_\_\_\_  
 Have you experienced any unexplained or rapid weight changes in the last six months? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ lbs



Please mark off the areas of your complaint on the diagram above.  
 Please use the following symbols on the pain diagram to accurately describe your condition.

Please mark off the areas of your complaint on the diagram below. Use the following symbols:  
**P = pain, N = numbness, T = tingling, B = burning, C = Cramping, S=sharp, A=aching**

Patient Name: \_\_\_\_\_

### ***Complaint History***

**Complaint 1:**

When did your complaint first begin? \_\_\_\_\_ Have you ever experienced this complaint before? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

Describe the type of pain/symptom you experience? \_\_\_\_\_

Does your problem travel into any other part of your body? Where? \_\_\_\_\_

Where exactly is the complaint area? \_\_\_\_\_

When do you notice the problem? \_\_\_\_\_

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? \_\_\_\_\_

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? \_\_\_\_\_

**Complaint 2:**

When did your complaint first begin? \_\_\_\_\_ Have you ever experienced this complaint before? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

Describe the type of pain/symptom you experience? \_\_\_\_\_

Does your problem travel into any other part of your body? Where? \_\_\_\_\_

Where exactly is the complaint area? \_\_\_\_\_

When do you notice the problem? \_\_\_\_\_

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? \_\_\_\_\_

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? \_\_\_\_\_

**Complaint 3:**

When did your complaint first begin? \_\_\_\_\_ Have you ever experienced this complaint before? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

Describe the type of pain/symptom you experience? \_\_\_\_\_

Does your problem travel into any other part of your body? Where? \_\_\_\_\_

Where exactly is the complaint area? \_\_\_\_\_

When do you notice the problem? \_\_\_\_\_

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? \_\_\_\_\_

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that I am responsible for all attorney fees or collection fees related to the collection of my account. I agree to pay interest at the rate of 1.5% per month (18% per annum) on any unpaid balance.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Information taken by \_\_\_\_\_ Date \_\_\_\_\_

**Dr. Ronald E. Adams DC**  
**NEUROLOGICAL ASSESSMENT FORM**

**NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

- |  | Right | Left |
|--|-------|------|
| <input type="checkbox"/> Are you left or right handed? _____   | Right | Left |
| <input type="checkbox"/> Have you had a head injury? _____   | YES   | NO   |
| <input type="checkbox"/> Do you currently experience or have a past history of vertigo or balance disorders? _____         | YES   | NO   |
| <input type="checkbox"/> Do you have any ringing or pressure in the ears? _____  | YES   | NO   |
| <input type="checkbox"/> Do you experience nausea? _____   | YES   | NO   |
| <input type="checkbox"/> Do you find that your balance is getting worse? _____   | YES   | NO   |
| <input type="checkbox"/> Do you have difficulties walking down stairs? _____   | YES   | NO   |
| <input type="checkbox"/> Do you have difficulty with math problems, or remembering numbers? _____                          | YES   | NO   |
| <input type="checkbox"/> Do you find yourself searching for words frequently when you speak? _____                         | YES   | NO   |
| <input type="checkbox"/> Have you noticed your ability to concentrate is getting worse? _____                              | YES   | NO   |
| <input type="checkbox"/> Do you get lost often or have a hard time with directions? _____                                  | YES   | NO   |
| <input type="checkbox"/> Do quick flashes of light on TV or loud noises bother you? _____                                  | YES   | NO   |
| <input type="checkbox"/> Do you feel like you need to wear sunglasses outside? _____                                       | YES   | NO   |
| <input type="checkbox"/> Has your handwriting changed in recent years? _____   | YES   | NO   |
| <input type="checkbox"/> Do you have a hard time swallowing? _____   | YES   | NO   |
| <input type="checkbox"/> Do you gag easily? _____  | YES   | NO   |
| <input type="checkbox"/> Do you experience blurriness in your vision or double vision? _____ ← <b>(CIRCLE)</b>             | YES   | NO   |
| <input type="checkbox"/> Do you have any changes in smell or smell foul things that are not present? _____                 | YES   | NO   |
| <input type="checkbox"/> Do you have any difficulty with taste or taste things differently than what you are eating? _____ | YES   | NO   |
| <input type="checkbox"/> Noticed clumsiness in hand coordination? Which hand? Right / Left ← <b>(CIRCLE)</b>               | YES   | NO   |
| <input type="checkbox"/> Do you have difficulty with short-term memory? _____  | YES   | NO   |
| <input type="checkbox"/> Have you been told or noticed any memory loss of past events? _____                               | YES   | NO   |
| <input type="checkbox"/> Noticed uneven sweating or temperature on one side of your body? _____                            | YES   | NO   |
| <input type="checkbox"/> Do you have any tightness, weakness or instability in your back or neck? ← <b>(CIRCLE)</b>        | YES   | NO   |
| <input type="checkbox"/> Do you have tightness, or feelings of weakness in your hands or legs? ← <b>(CIRCLE)</b>           | YES   | NO   |
| <input type="checkbox"/> Do you ever have any numbness or tingling in your hands, legs, or face? ← <b>(CIRCLE)</b>         | YES   | NO   |
| <input type="checkbox"/> Do you have any difficulty with falling asleep or staying asleep? _____                           | YES   | NO   |
| <input type="checkbox"/> Do you get motion sickness easily (car sick or sea sick)? _____                                   | YES   | NO   |
| <input type="checkbox"/> Do you ever experience flashes of light in your visual field? _____                               | YES   | NO   |
| <input type="checkbox"/> Do you ever experience dry eyes or mouth? _____ ← <b>(CIRCLE)</b>                                 | YES   | NO   |
| <input type="checkbox"/> Do you ever experience increase tearing or salivation? _____ ← <b>(CIRCLE)</b>                    | YES   | NO   |
| <input type="checkbox"/> Do you ever have slurred speech? _____  | YES   | NO   |
| <input type="checkbox"/> Noticed any drooping of your eyelids or facial muscles? _____ ← <b>(CIRCLE)</b>                   | YES   | NO   |
| <input type="checkbox"/> Do you ever notice increased heart rate (tachycardia) or pulse during the day? _____              | YES   | NO   |
| <input type="checkbox"/> Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? _____       | YES   | NO   |
| <input type="checkbox"/> Do you experience Deja Vu? _____  | YES   | NO   |
| <input type="checkbox"/> Does driving cause you fatigue, headaches, or any other symptoms? _____ ← <b>(CIRCLE)</b>         | YES   | NO   |
| <input type="checkbox"/> Does working on a computer cause you fatigue, headaches or other symptoms? _____                  | YES   | NO   |
| <input type="checkbox"/> Have you lost your interest in hobbies and functions that you used to enjoy? _____                | YES   | NO   |
| <input type="checkbox"/> Do you have a hard time motivating yourself to engage in activities? _____                        | YES   | NO   |
| <input type="checkbox"/> Do you ever have fluttering of the eye or noticed you are blinking frequently? _____              | YES   | NO   |
| <input type="checkbox"/> Do you have difficulty distinguishing right and left? _____                                       | YES   | NO   |

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_