REACTIVE
NEURO PHYSICAL ADVANCEMENT CENTER

Welcome
Patient Information

Today's Date: ____________________ Referred By: _______________________________

Name: _______________________________________ Date of Birth: __________________

Male: ___ Female: ___ Age: ____ What do you preferred to be called: _______________

Home Address: ____

____

Home Phone: _____________ Cell Phone: ______________ Cell Carrier: _____________

Email: ____________________________ Employer: _________________________________

Employer's Address: ____

Occupation: ___________________________ Work Phone: __________________________

FAMILY INFORMATION

Marital Status: ________ Spouse's Name: _______________ Date of Birth: _____________

Spouse's Employer: ___________________________ Spouse's Work Phone: ____________

Number of Children: ____________

MEDICAL HISTORY

List any prescriptions/over the counter medications you are taking: ______________________

____

List any previous surgeries/treatments with dates: ____________________________________

____

List any serious accidents/injuries with dates: _______________________________________

IS THERE HISTORY IN YOUR FAMILY OF:

___Diabetes ___Heart Disease ____Stroke ___Cancer ___Other Explain: ____________

____

Current Complaint(s):____

____

How long have you had this condition?____

How did this occur?____

What aggravates your condition?____

What relieves your condition?____

Does the pain radiate or travel in other areas? _____Yes _____No

If yes, where?____

Is the condition getting progressively worse? ___ Yes ___No ___Constant ___Comes and Goes

Is the condition interfering with your: ___ Work ___Sleep ___Daily routine ___Other

Other doctors who have treated this condition:______________________________________

Have you had previous chiropractic care?____

List all exercises/sports you participate in:____

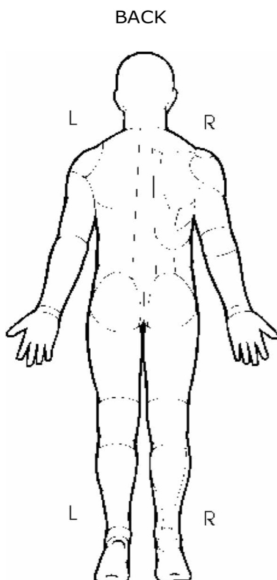
____

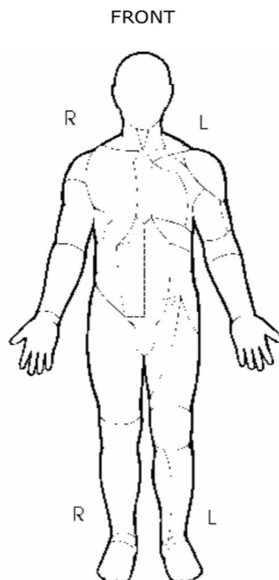
Weekly Frequency and Duration of your exercise/sports program:_________________________

____

Severity of Pain

Please MARK an X on the BODY DIAGRAM where your pain is.
Then LIST the REGION of pain and CIRCLE SEVERITY NUMBER on the lines to the right.
(1=least 10=greatest)





1.____________________________
1 2 3 4 5 6 7 8 9 10

2.____________________________
1 2 3 4 5 6 7 8 9 10

3.____________________________
1 2 3 4 5 6 7 8 9 10

4.____________________________
1 2 3 4 5 6 7 8 9 10

5.____________________________
1 2 3 4 5 6 7 8 9 10

____
PLEASE PRINT NAME AND DATE