



2402 Macy Drive, Roswell, Georgia 30076 • (770) 552-1552
Matthew Eisen, D.C.

Welcome to Eisen Family Chiropractic - where your health always comes first. If you are reading this, you have been fortunate enough to qualify for a consultation with Dr. Eisen. This however does not mean that your case has been accepted. Your consultation today will help determine if you are a legitimate candidate for our successful program of care or if your case will need to be referred out to another physician or specialist.

Today's Date
Name Age Date of Birth Sex: M F
Address
City State Zip Email
Home Phone Work Phone Cell Phone
Best Place To Reach You (circle one) Home / Work / Cell / Email - May we leave a message for you? Yes No
Employer Occupation Length of Employment
Work Address City State Zip
SS# Drivers License # Marital Status: S M W D
Spouses Name Spouses Date of Birth Number of Children
Spouses Occupation Spouses Company

Most new patients are referred from friends & family - How did you hear about Dr. Matt?

Insurance Information - Please give the front desk your insurance card and drivers license.

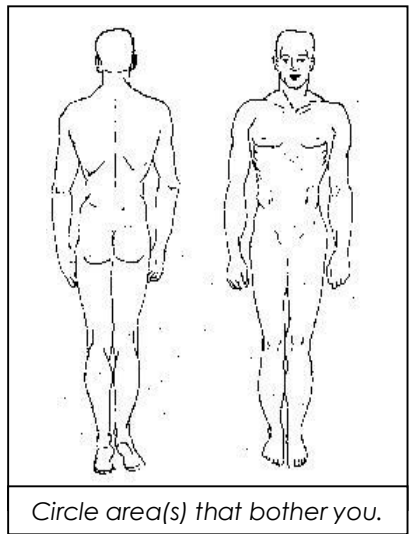
Insurance Company Policy Number
Name of Primary Primary's Date of Birth

Reason(s) for Today's Visit

- Wellness/Prevention
Symptom Relief
Auto Accident
Worker's compensation
Other

Previous Chiropractic Care: Yes No
Chiropractor's name
Reason for Care

Were you on a spinal maintenance program to maximize the future stability of your spine? Y N
Did you follow the program? Y N
If not, why?
Why are you changing Chiropractor's?
What are your health goals?
How do you plan to achieve them?



Circle area(s) that bother you.

PATIENT SIGNATURE DATE



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What Brings You to Our Office Today?

• Number One Complaint: _____

- Date when symptom first appeared _____ • Was the Onset: Gradual Sudden Progressive over Time
• What makes it feel better? _____
• What makes it feel worse? _____
• Type of Pain: Sharp Dull Ache Burn Throb • Do you experience Numbness or Tingling? Yes No
• Does the pain radiate or travel into your Upper Arm Lower Arm Upper Leg Lower Leg
• How often do you experience these symptoms? 100% 75% 50% 25% 10%
• Pain Intesity: No Pain Mild Pain Moderate Pain Unbearable Pain
• Have you ever been to another doctor for this problem? Yes No
• Doctor _____ Date _____

• Second Complaint: _____

- Date when symptom first appeared _____ • Was the Onset: Gradual Sudden Progressive over Time
• What makes it feel better? _____
• What makes it feel worse? _____
• Type of Pain: Sharp Dull Ache Burn Throb • Do you experience Numbness or Tingling? Yes No
• Does the pain radiate or travel into your Upper Arm Lower Arm Upper Leg Lower Leg
• How often do you experience these symptoms? 100% 75% 50% 25% 10%
• Pain Intesity: No Pain Mild Pain Moderate Pain Unbearable Pain
• Have you ever been to another doctor for this problem? Yes No
• Doctor _____ Date _____

• Third Complaint: _____

- Date when symptom first appeared _____ • Was the Onset: Gradual Sudden Progressive over Time
• What makes it feel better? _____
• What makes it feel worse? _____
• Type of Pain: Sharp Dull Ache Burn Throb • Do you experience Numbness or Tingling? Yes No
• Does the pain radiate or travel into your Upper Arm Lower Arm Upper Leg Lower Leg
• How often do you experience these symptoms? 100% 75% 50% 25% 10%
• Pain Intesity: No Pain Mild Pain Moderate Pain Unbearable Pain
• Have you ever been to another doctor for this problem? Yes No
• Doctor _____ Date _____

PATIENT SIGNATURE _____ DATE _____



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Few More Questions About Your Main Complaints...

1. What do you hope will happen today as a result of your consultation with the Doctor?

2. Since your problem became this severe what three things has it caused you to miss the most (ie: work, chores, hobbies, sports, school, leisure activities, time with family or friends?)

3. How has your life changed since the onset of your problem?

4. What activities are you limited in?

5. What kinds of treatments have you received?

Epidural:	How Many _____	Date _____	Did it Help? _____
Physical Therapy:	How Long _____	Date _____	Did it Help? _____
Medications:	How Many _____	Date _____	Did it Help? _____
Surgery:	Type _____	Date _____	Did it Help? _____
Other _____		Date _____	Did it Help? _____

6. If you cannot find a solution to this problem what do you think will happen to you?

7. What do you hope Dr. Matt will tell you today?

8. Describe what you hope or think he might be able to do for you.

9. Describe what will be different in your life once your condition improves.

PATIENT SIGNATURE _____ DATE _____



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Please list all medications and the corresponding symptom or condition you are taking or have in past year:

Please list all previous surgeries and dates:

REVIEW OF SYSTEMS FORM - Have you currently have or had in the last 12 months ANY of the following: (Mark C for Current. X for in last 12 mos.)

GENERAL

Chills ___ Convulsions ___ Dizziness ___ Fainting ___ Fatigue ___ Fever ___ Headache ___ Loss of Sleep ___ Bronchitis ___ Allergy ___ (to what _____) Loss of Weight ___ Nervousness ___ Wheezing ___ Numbness in HANDS AND FEET ___

CARDIOVASCULAR

High Blood Pressure ___ Low Blood Pressure ___ Pain over heart ___ Poor Circulation ___ Rapid Heartbeat ___ Slow Heartbeat ___ Stroke ___ TIA ___ Swollen Ankles ___ Varicose Veins ___ Aortic Aneurysm ___ Bruise Easily ___ Previous Heart Problem ___ (Describe _____)

DISEASES/CONDITIONS

Appendicitis ___ Anemia ___ Arthritis ___ Alcoholism ___ Abdominal Surgery ___ Bleeding Disorder ___ Blood Clot(s) ___ Breathing Difficulty ___ Cancer ___ Cholesterol High ___ Colon Problems ___ Diabetes ___ Depression ___ Epilepsy ___ Eczema ___ Eating Disorder ___ Glaucoma ___ HIV + ___ Heart Disease ___ Hernia ___ Headaches ___ Influenza ___ Kidney Disease ___ Liver Disease ___ Low back Pain ___ Mental Illness ___ Measles ___ Mumps ___ Pleurisy ___ Pneumonia ___ Polio ___ Prostate Problems ___ Hyperthyroid ___ Hypothyroid ___ Rectal Surgery ___

EARS/EYES/NOSE/THROAT

Asthma ___ Crossed Eyes ___ Double Vision ___ Blurred Vision ___ Difficulty Swallowing ___ Deafness ___ Hearing Loss ___ Ear Pain ___ Thyroid Problem ___ Nose Bleeds ___ Sinus Problems ___ Sore Throats ___

GASTRO-INTESTINAL

Gas ___ Colon Trouble ___ Constipation ___ Diarrhea ___ Gallbladder Trouble ___ Hemorrhoids ___ Liver Trouble ___ Nausea ___ Stomach Ache ___ Poor Appetite ___ Poor Digestion ___ Vomiting ___ Vomiting Blood ___ Rectal Bleeding ___ Bloating ___

GENITO-URINARY

Blood in Urine ___ Frequent Urination ___ Inability to control urine ___ Kidney Infection ___ Painful Urination ___ Prostate Trouble ___ Painful Urination ___

FOR MEN ONLY

Lump in testicles ___ Any genital discharge ___

FOR WOMEN ONLY

Menstrual Cramps ___ Excessive menstrual flow ___ Hot Flashes ___ Irregular Cycle ___ Painful periods ___ Birth Control Pills ___ Abnormal Pap Smear ___

MUSCLE/JOINT/BONE

Backache ___ Foot Trouble ___ Pain Between Shoulders ___ Painful Tailbone ___ Stiff Neck ___ Spinal Curvature ___ Swollen Joints ___

NEUROLOGIC

Seizures ___ Dizziness ___ Hand Trembling ___ Weakness ___ Difficulty with speech ___ Loss of memory ___ Loss of coordination ___

RESPIRATORY

Chest Pain ___ Chronic Cough ___ Difficulty Breathing ___ Coughing/Spitting Blood ___

PATIENT SIGNATURE _____ DATE _____