

**Comfort Chiropractic \*3672 Capital Blvd \*Raleigh NC 27604**  
919-872-1050(P) 919-872-5025(F)

CONFIDENTIAL PATIENT INFORMATION

*Welcome to Comfort Chiropractic! Please complete this form **Completely and Accurately**. Your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. If you need help, please ask the receptionist. This information will be held in the strictest confidence.*

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Who referred you to Dr. Orlasky? \_\_\_\_\_

**Patient Data**

Your Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Martial Status ( )M ( )S( ) W ( ) D Number of Children: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_ Their Phone: (\_\_\_\_) \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Present Complaint**

What Are Your Symptoms? \_\_\_\_\_

Other Doctors Seen for this Condition: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Yrs. \_\_\_\_\_ Mos. Have you had a similar condition in the past?

( ) Yes ( ) No. If yes, Explain: \_\_\_\_\_

What caused your present condition? \_\_\_\_\_

What aggravates this condition? \_\_\_\_\_

Your condition is: ( ) getting progressively worse ( ) stay the same ( ) getting better ( ) constant pain

( ) comes and goes Your condition interferes with your: ( ) work ( ) sleep ( ) daily routine ( ) other \_\_\_\_\_

Previous Chiropractic Care? ( ) Yes ( ) No. When? \_\_\_\_\_ For what condition? \_\_\_\_\_

**Medical History**

Have you been treated by any Doctor in the past year? ( ) Yes ( ) No.

If yes, what for? \_\_\_\_\_

Drugs you now take: ( ) Nerve pills ( ) pain killers ( ) muscle relaxers ( ) pep pills ( ) tranquilizers ( ) insulin

( ) Birth Control ( ) blood pressure ( ) others: \_\_\_\_\_

List any medication allergies: \_\_\_\_\_

Do you smoke? ( ) yes ( ) no \_\_\_\_\_ packs per ( ) day ( ) week for \_\_\_\_\_ ( ) months ( ) years.

Quit Smoking \_\_\_\_ ( ) yrs ( ) mo ago.