

Dr. James M. Cormier, Chiropractor • 17 Pierce Avenue, Suite B, Fitchburg, MA 01420 • (978) 345-1224 • Fax (978) 345-1418 • cormier-chiropractic.com

## Patient and/or Insured Info

Date

### Patient

Name (First, Middle, Last) Nickname:

Street Address

City, State, Zip

Telephone (Home, Work, Cell)

Email

Marital Status

Social Security Number

Date of Birth Age Sex  
 Male  Female

Occupation

Employed by

Name of Spouse or Parent

PCP name

Relation to Insured  
 Self  Spouse  Child  Other \_\_\_\_\_

### Insured Same as Patient

Name (First, Middle, Last) Nickname:

Street Address

City, State, Zip

Telephone (Home, Work, Cell)

Email

Marital Status

Social Security Number

Date of Birth Age Sex  
 Male  Female

Occupation

Employed by

Name of Spouse or Parent

PCP name

Relation to Insured  
 Self  Spouse  Child  Other \_\_\_\_\_

## Insurance Info

### Primary

Company Name

Street

City, State, Zip

Telephone

Policy Number

Group Number

I.D. Number

### Secondary

Company Name

Street

City, State, Zip

Telephone

Policy Number

Group Number

I.D. Number

## Workmans Comp / Attorney Info

### Workmans Comp

Employer / Attorney

Street Address

City, State, Zip

Telephone

### Attorney

Employer / Attorney

Street Address

City, State, Zip

Telephone

## Other

Reason for your visit?

Who referred you to our office?

Have you had chiropractic care before? (Doctors name)



## CONFIDENTIAL PATIENT INFORMATION

### Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

### Health Concerns

Please list your health concerns according to their severity

Rate of severity  
 1 = mild  
 10 = worst  
 imaginable

When did this episode start?

If you had this condition before, when?

Did the problem begin with an injury?

% of the time pain is present

1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same?  Getting better?  Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition?

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)

"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)

Medical Doctor

Dentist

Other (please describe)

Doctors' details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?



# Chiropractic Wellness Center

Tel: (978) 345-1224  
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www.cormier-chiropractic.com

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

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Is this condition interfering with any of the following:

Work  Sleep  Daily routine  Sports/exercise  Other  (please explain):

What lesson(s) have you taken home from your healing process to date?

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## General Health History

*Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!*

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes  No

## Current Medicines and Supplements

Please list all medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

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Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

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Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would you help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

## Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

**D** - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week  
**FM** - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: \_\_\_\_\_

## Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) \_\_\_\_\_



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## Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work: \_\_\_\_\_ At home: \_\_\_\_\_ At play: \_\_\_\_\_

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits: \_\_\_\_\_ Exercise habits: \_\_\_\_\_ Sleep: \_\_\_\_\_ General health: \_\_\_\_\_ Mind set: \_\_\_\_\_

How do you grade your physical health?

Excellent  Good  Fair  Poor  Getting better  Getting worse

How do you grade your emotional/mental health?

Excellent  Good  Fair  Poor  Getting better  Getting worse

Is there anything else which may help to better understand you which has not been discussed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why are you here at this point in time?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

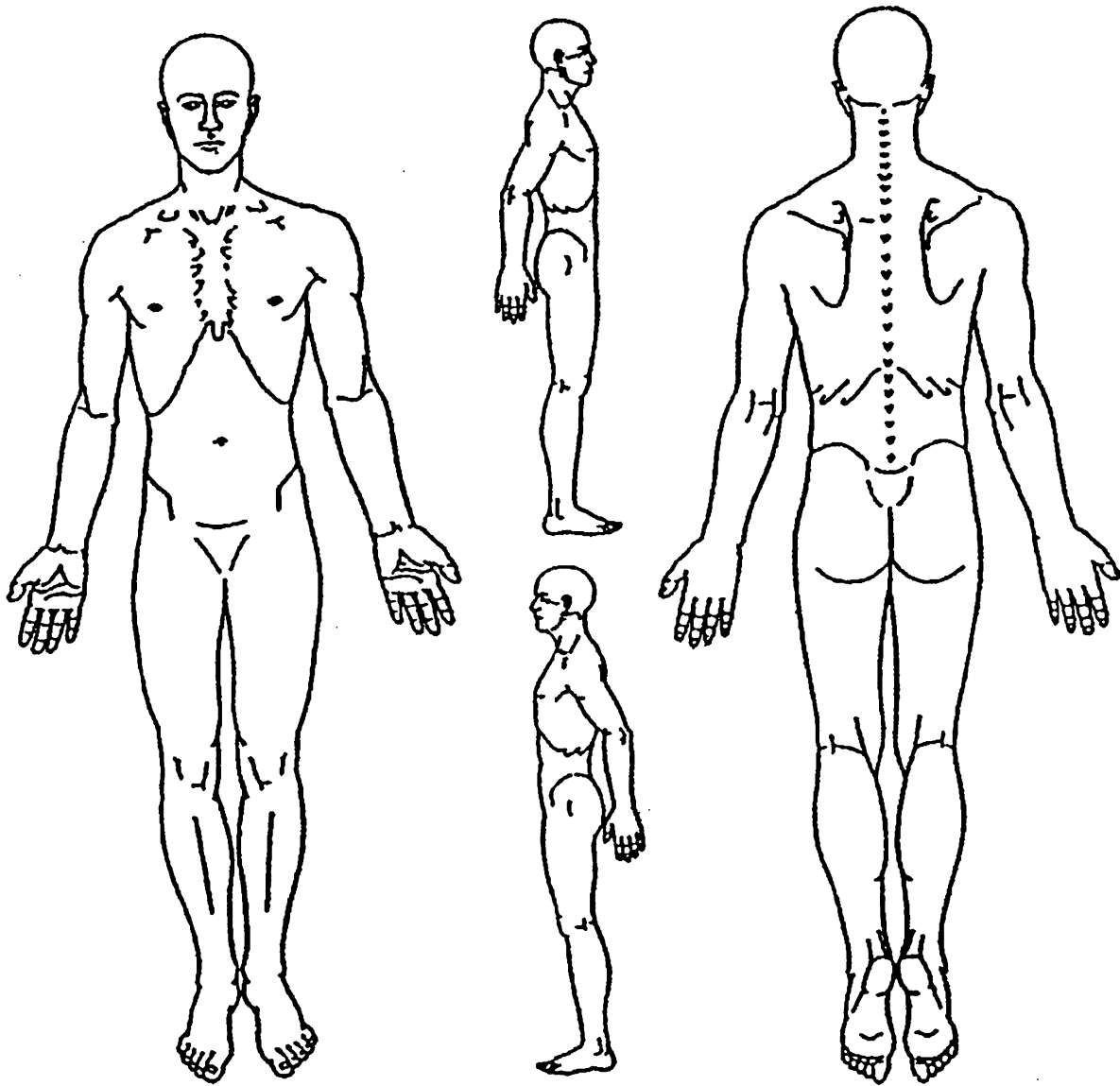
Signature: \_\_\_\_\_

# SYMPTOM SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

### KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_