GOODSIR CHIROPRACTIC CENTER

DR. Michelle R. Goodsir
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Devon, PA 19333
(610) 687-1669

PERSONAL INFORMATION FORM

Patient Number _____ Date _____

Name _____ Date of Birth _____ Age _____ Sex M F

Address _____ City _____ State _____ Zip Code _____

Phone(Home) #: _____ Work #: _____ Social Security # _____

Occupation _____ # Hours per week currently working _____

Name of Spouse _____ Occupation _____

Names of Children _____ Age(s) _____

Have you ever had chiropractic care? Yes No If so, with whom? _____ Referred by _____

Do you have any known congenital anomalies?_____

What is your major complaint? _____

HISTORY

CHIEF COMPLAINT(S) - Problem List: (O-onset)

☐ Headaches O: _____ ☐ Low Back Pain O:_____ ☐ Upper Back Pain O: _____
☐ Neck Pain O: _____ ☐ Mid Back Pain O:_____ ☐ Leg Pain/Paresthesia Right Left
☐ Arm Pain/Paresthesia Right Left

Doctor for this condition? _____ Name _____
Is this condition getting better of worse? _____ Is it constant or does it come and go ?_____

SYMPTOM DESCRIPTION:

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
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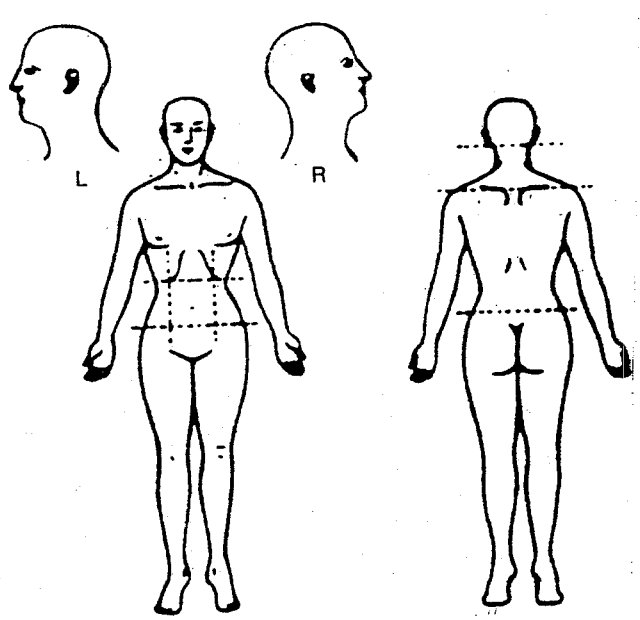

Summarize your present complaints and duration

_____
_____
_____
_____
_____
_____
_____