Thorpe Chiropractic Office

Dr. Kent R. Thorpe

Patient Name: ____ **Date:** ___________

Give a brief detailed description of the problem you are currently experiencing:

____

____

When did the problem start? ______________ Is it getting worse? □ Yes □ No

____

What seemed to be the initial cause:

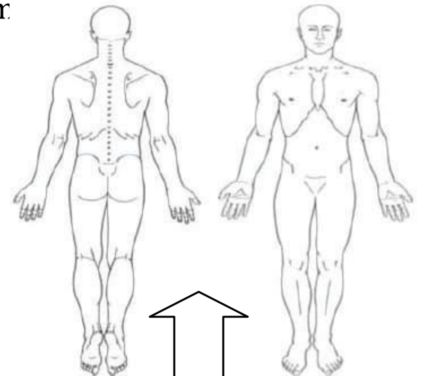
____

How often do you experience your symptoms?

- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (26-50% of the day)
- ○ Intermittently (0-25% of the day)

How are your symptom

- ○ Getting Better
- ○ Not Changing
- ○ Getting worse



Indicate where you have pain or other symptoms

		None										Unbearable
How bad are your symptoms at their:	a. worst	0	1	2	3	4	5	6	7	8	9	10
	b. best	0	1	2	3	4	5	6	7	8	9	10

What describes the current nature of your symptoms?

- ○ Sharp
- ○ Dull ache
- ○ Numb
- ○ Shooting
- ○ Burning
- ○ Tingling

Past health history

Have you…	Yes	No	If yes, include date & provider seen
...been hospitalized in the last 5 years?	□	□	______________________________
...been diagnosed with Diabetes	□	□	______________________________

Type I____or Type II_____

Vitals

Height ________ Weight ________ Blood Pressure ________

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals…

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by

Please be as specific as possible

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____

Do you have allergies? □Food □Environmental □Medication

List Type of Allergy and Reaction

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212 HIghbridge Street, **Fayetteville, NY 13066**

Phone: (315) 637-0706 **Fax: (315) 637-0708**

www.thorpe-dc.com