PAHOA Chiropractic
15-2891 Pahoa Village Rd.
Pahoa, HI 96778
(808) 965-6623
pahoachiropractic@outlook.com

Patient Information

Name: ______________________________ SS#: ______________
Birthday: ______________ Age: ______ Sex: M F Marital Status: S M O
Phone: ______________ Home /Cell Email: ______________________
Address: ______________________ City: ____________State: _____ Zip: _______
Employer: ___________________Occupation: ____________ Work Phone: ___________
Purpose of visit: ____
Where is your pain? ______________________ When did it start? ______________
What were you doing when you first noticed it? ______________________________
When do you feel it most? AM PM Standing Sitting Walking Lying Down
What does it feel like? Sharp Dull Stabbing Aching Other ________________
Was this caused by an accident? Yes No
If yes, what kind of accident? Auto Work Home Other____________
Date of accident: ________________ Have you made a report? Yes No
Have you seen a chiropractor before? Yes No
How did you hear about us? ____

Pain Disablity Index

On the diagram to the right, please indicate where you are experiencing pain or other symptoms

A = Ache B = Burning N = Numbness
P = Pins and Needles S = Stabbing
O = Other

PAIN SCALE
Please circle the number that best discribes your pain

0 1 2 3 4 5 6 7 8 9 10
Slight Moderate Severe

R L
L R

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Do you suffer from any of the following conditions (please circle all that apply)

Allergies	Digestive Problems	Jaw Pain
Arthritis	Depression	Low Back Pain
Asthma	Ears Ringing	Leg Pain
Arm/Shoulder Pain	Fatigue	Mid Back Pain
Blurred Vision	Foot/Toe Numbness	Neck Pain
Carpal Tunnel	Gout	Tension
Diabetes	Hand/Finger Numbness	
Difficulty Sleeping	Headaches	
Dizziness	Heartburn/Acid Reflux	

Have you seen any other health care professional for your conditon? Yes No

If yes, who? MD DO DC PT Other ______________________________

Name ________________________ Treatment ____________________ Did it help? Yes No

List any past injuries from falls, auto accidents, fractures, sports injuries, etc.

____

____

List any current medications you are taking

____

____

Who is your chiropractor? ____

What did you go there for? _____________________________________ Did it help? Y N

Why did you stop care? ____

PAYMENT IS EXPECTED AT TIME OF SERVICE

Who is responsible for this account? ____

Relationship to patient: Self Spouse Parent Guardian Other_______________

Insurance Company: ______________________ Policy #__________________________

Please print your name: ____

Signature of patient, parent, guardian: ____

The above signed consents to treatment by the chiropractors employed by Dr. Melissa Merrill, DC at Pahoa Chiropractic. Date: __________________