Porter Chiropractic PLLC
715 Wheatley Rd.
Ashland, KY 41101

Dwain P. Porter, DC, MS
606-329-1148

Patient Information
Please complete entire form

Patient Name _____ Date _____
Address _____ ____Male____ Female____
City_____ State_____ Zip _____ Date of Birth _____
S.S. Number_____ Ht. _____ Wt._____

Phone Number: (_____)_____
Email address _____

Method of payment, Name and type of Health Insurance company. _____
_____

Employer_____Type of work_____
In case of emergency notify _____ Phone Number (___) _____

To all females for x-ray Purpose: I am not pregnant and have no reason to believe I am pregnant.
If pregnant please initial here **_____.**

HEALTH HISTORY

Current problem is located where? _____
When did current illness begin?_____ Date of last Chiropractic visit_____
How often do you experience the symptoms? Constantly, Frequently, Occasionally,
How would you describe the type of pain? Please circle! Sharp, Dull, Achy, Burning, Shooting, Stiff, Numb, Tingling.

Scale of 1 to 10 (10 being the worst pain) describe:_____
What makes the pain worse? _____
What alleviates the pain? _____
What medical attention have you received for this current illness? _____
Have you received an MRI, CT scan, EMG, NCV, or Xray? _____
List current medications for this illness: _____
List all previous fractures: _____
List all previous surgeries: _____
List all medications: _____
List all previous diagnosed diseases: _____
Type of exercise and frequency: _____

Would you like to discuss nutritional healing, diet or weight loss programs? _____

_____ _____
Signature Date