Welcome

Date: _____

About You

Patient Name _____ (Last) _____ (First) _____ (M.I.)

Male ☐ Female ☐ I would prefer to be called: _____

Birthdate _____ Age _____ SS# ___ - ___ - ___

Street Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile _____

Email Address _____

Occupation _____

Employer _____ How Long? _____

Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name _____ Spouses Date of Birth _____

Who may we thank for your referral? _____ # of Children _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No

Your Health History

Date of last:

Physical Exam _____ Spinal X-Ray _____

Spinal Exam _____ MRI, CT or Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you've had any of the following:

AIDS/HIV	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Prostate Issues	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheum. Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Sinus Condition	☐ Yes	☐ No
Backaches	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Other Headaches	☐ Yes	☐ No	Thyroid Issues	☐ Yes	☐ No
Concussion	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Muscular Dystrophy	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Digestive Disorder	☐ Yes	☐ No	Neuritis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Dizziness/Vertigo	☐ Yes	☐ No	Numbness	☐ Yes	☐ No	Other		
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	_____		
Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	_____		
Fractures	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please describe any injuries or surgeries you have had:

_____

_____

Your Concerns

What is your major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms ☐ constant? ☐ coming and going? ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

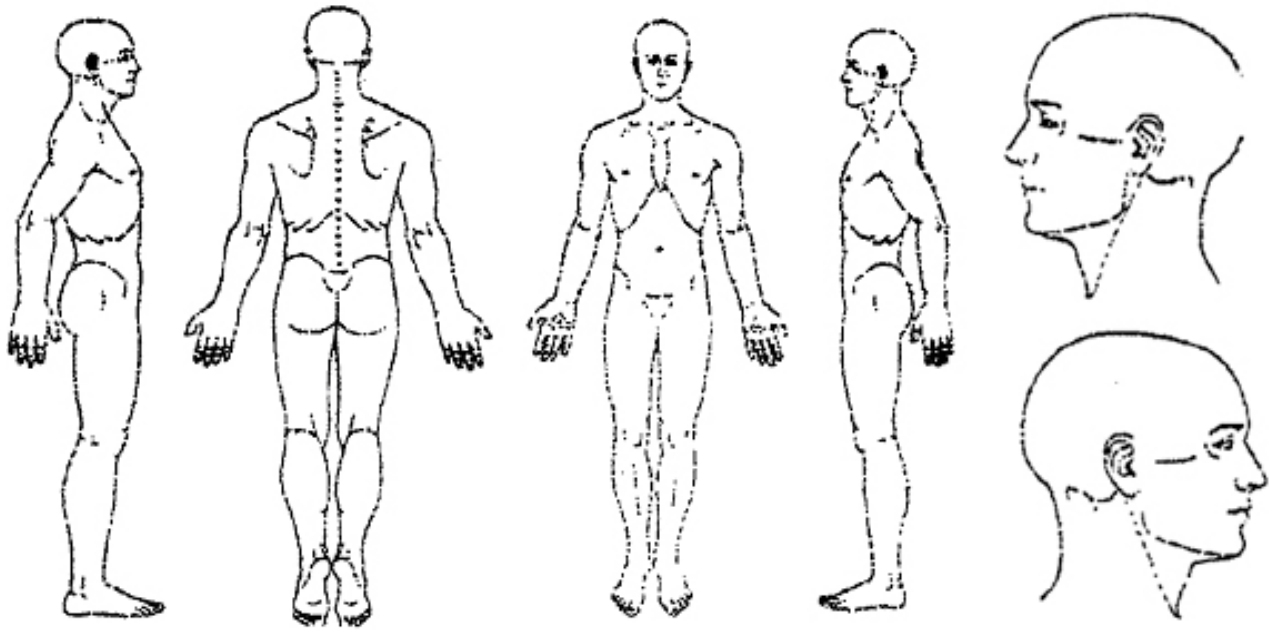
Other doctor(s) that treated you for this condition: _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of pain: (Check applicable boxes and place an X on pain area)

☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting

☐ Burning ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Other



How often do you have this pain? _____

Does it interfere with Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Who else have you seen for this problem? _____

Other comments or concerns regarding your condition:

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____ Date _____

If patient is under 18:
Guardian Signature _____ Date _____