

CONTACT INFORMATION

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone (H): _____
 Phone (Cell): _____
 Phone (W): _____
 Email: _____
 Date of Birth: _____ Age: _____
 Gender: Female Male
 Marital Status S M D W

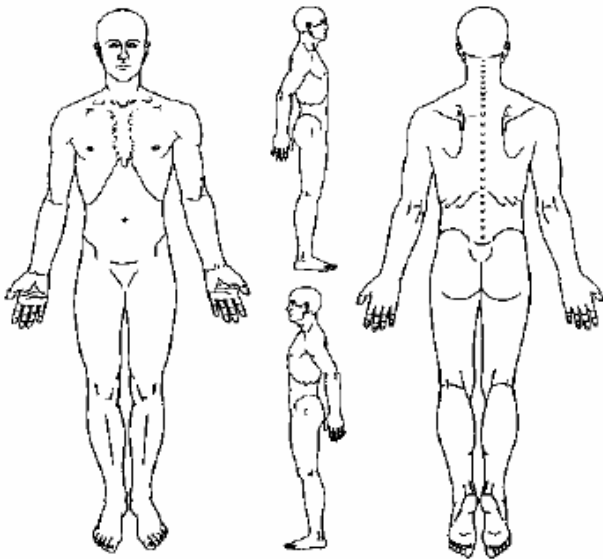
Referred by: _____
 Occupation: _____
 Employer: _____
 Spouse's Name: _____
 Spouse's Occupation: _____
 Emergency Contact: _____
 Relationship: _____
 Phone (Cell): _____
 Phone (Other): _____
 Would you like us to check your Insurance? YES NO
 Company: _____ SS #: _____

PERSONAL & FAMILY HISTORY

How many times have you visited a Chiropractor in your lifetime? _____ Never
 When was your last complete spinal examination including x-rays? _____ Never
 Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? Yes NO
 It is well known that families who maintain strong healthy, well-aligned spines have much improved health. Does anyone in your family have any health concerns? Yes NO
 Spouse Name: _____ Age: _____ Health Challenge: (ex: Fatigue) _____
 Child Name: _____ Age: _____ Health Challenge: (ex: Hyperactivity) _____
 Child Name: _____ Age: _____ Health Challenge: (ex: ADHD) _____
 Child Name: _____ Age: _____ Health Challenge: (ex: Bedwetting) _____
 Child Name: _____ Age: _____ Health Challenge: (ex: Allergies) _____

CURRENT/PRESENT HEALTH PROBLEMS

Current Health Complaint(s)/ Reasons for Consulting Our Office: _____



Please outline on the diagram
the area of discomfort.

- 1 Present Complaint: _____
- 2 When did the pain/problem start: _____
- 3 What is the type of pain you are experiencing?
 Sharp Dull Aching Numbness Throbbing Other
- 4 What is the severity of your pain?
Least Pain - 1 2 3 4 5 6 7 8 9 10 - Severe Pain
- 5 Is your problem worse at certain times of the day?
 Morning Afternoon Evening Night Other
- 6 Are there any activities/movements that are painful to perform? _____
- 7 Is this condition getting progressively worse?
 YES NO Unsure
- 8 Does your problem interfere with your:
 Work Home Activities Sleep Other
- 9 Does the problem/condition refer anywhere? (Ex: into right arm) _____
- 10 What have you done for the problem/condition? (Ex: ice/heat) _____
- 11 Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High
- 12 Is today's visit related to any one of the following:
 Work Related Auto Accident Home Injury Fall Other

Patient Signature: _____

Date: _____

HAVE YOU BEEN DIAGNOSED WITH HAVING:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> *Broken Fractured Bones | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> *Cancer | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> *Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> *Osteoarthritis | <input type="checkbox"/> Excessive/Bleeding Disorders | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> *Rheumatoid Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Other: _____ |

*Explanation:

CURRENT LIFESTYLE HABITS

- | | | | | | |
|----------------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| Do/Did you smoke? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Do you drink coffee/caffeine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you exercise regularly? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Do you eat fast-food? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have stress? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Do you consume white sugar? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you drink alcohol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | | |

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

- | | | |
|--|--|--|
| <p>MUSCULO-SKELETAL CODE</p> <input type="checkbox"/> Arm Pain
<input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> General Stiffness
<input type="checkbox"/> Herniated Disk
<input type="checkbox"/> Jaw Pain/Clicking Jaw
<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Pain Between Shoulders
<input type="checkbox"/> Walking Problems <p>NERVOUS SYSTEM CODE</p> <input type="checkbox"/> Cold/Tingling Hands or Feet
<input type="checkbox"/> Confusion/Depression
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness
<input type="checkbox"/> Pinched Nerves
<input type="checkbox"/> Pins and Needles
<input type="checkbox"/> Stress/Tension | <p>GASTRO-INTESTINAL CODE</p> <input type="checkbox"/> Abdominal cramps
<input type="checkbox"/> Constipation
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Frequent Nausea
<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gas/Bloating After Meals
<input type="checkbox"/> Heartburn/Indigestion
<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Poor/Excessive Appetite
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Weight Problems <p>C-V-R CODE</p> <input type="checkbox"/> Chest Pains
<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Lung Problems/Congestion
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Stroke
<input type="checkbox"/> Varicose Veins | <p>EENT CODE</p> <input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Ear Aches
<input type="checkbox"/> Ears Ring
<input type="checkbox"/> Hearing Difficulty
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Visual Problems <p>GENITO-URINARY CODE</p> <input type="checkbox"/> Bladder Trouble
<input type="checkbox"/> Discolored Urine
<input type="checkbox"/> Painful/Excessive Urination <p>GEN CODE</p> <input type="checkbox"/> Fatigue
<input type="checkbox"/> Allergies
<input type="checkbox"/> Fever
<input type="checkbox"/> Headaches
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Migraines <p>FEMALES ONLY</p> <input type="checkbox"/> Menstrual Irregularity
<input type="checkbox"/> Trouble Getting Pregnant
<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Miscarriage
Are you pregnant?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unsure |
|--|--|--|

FAMILY HEALTH HISTORY

	Father	Mother	Spouse	Brothers	Sisters	Children
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus & Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Do Not Write Below This Line

Patient Accepted for Care: YES NO Referred **Doctor's Signature:** _____