Name_____ Preferred name_____

Address _____

City/State/Zip _____

Phone #s (home)_____ (cell) _____

Is it okay to contact you at work? ❍ no ❍ yes Work #_____

E-mail address _____ Web site _____

SS# _____ Birthdate _____ Age_____

Occupation_____ Employer _____

Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages_____

_____

Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) _____

_____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

Favorite hobbies or interests _____

What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? ❍ no ❍ yes

How did you find out about our office? _____

Is this appointment related to ❍ work ❍ sports ❍ auto

❍ personal injury ❍ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? ❍ no ❍ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ❍ no ❍ yes If yes, what month? _____

Current Health

What are your most pressing health concerns? _____

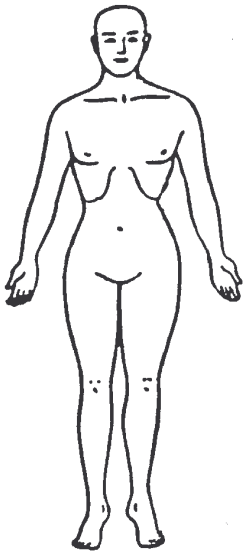
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent
❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

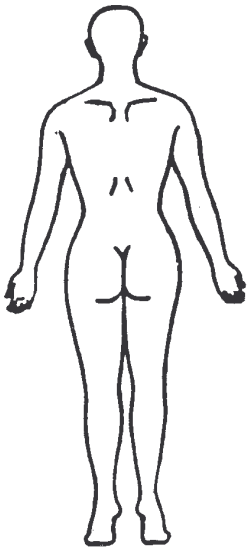
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking ❍ bending ❍ lying down ❍ weather

Please explain _____

Do you feel ❍ cramps ❍ burning ❍ other _____
❍ swelling ❍ stiffness

Do your symptoms interfere with ❍ work ❍ sleep ❍ other _____
❍ day-to-day activities ❍ play

Please explain _____

_____

On a scale of 1-10 *(1 least, 10 most)*, please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Do you have, or have you had, any of the following (*please check ☑ all that apply*)

❍ pneumonia	❍ mumps	❍ influenza	❍ rheumatic fever	❍ smallpox
❍ pleurisy	❍ polio	❍ chickenpox	❍ thyroid disease	❍ diabetes
❍ epilepsy	❍ cancer	❍ depression	❍ whooping cough	❍ anemia
❍ eczema	❍ measles	❍ arthritis	❍ heart disease	❍ rashes

If you have ever been diagnosed with another disease or condition, please describe_____

_____

Do you use ❍ coffee ❍ tea ❍ artificial sweeteners ❍ sugar
❍ alcohol ❍ cigarettes ❍ recreational drugs

Have you ever suffered from (*please check ☑ all that apply*)

❍ neck pain	❍ stuffy nose	❍ discolored urine
❍ low back pain	❍ allergies	❍ gas/bloating after meals
❍ headache	❍ fainting	❍ heartburn
❍ migraines	❍ weight loss	❍ colitis
❍ arm back/tingling	❍ poor appetite	❍ irritable bowel
❍ shoulder pain	❍ excessive appetite	❍ black or bloody stools
❍ hand pain/tingling	❍ nervousness	❍ constipation
❍ leg pain/tingling	❍ confusion	❍ hemorrhoids
❍ jaw pain	❍ depression	❍ liver problems
❍ chest pain	❍ dental problems	❍ stroke
❍ lung problems	❍ excessive thirst	❍ paralysis
❍ heart problems	❍ frequent nausea	❍ tingling
❍ abnormal blood pressure	❍ vomiting	❍ numbness
❍ irregular heartbeat	❍ prostate problem	❍ fatigue
❍ ankle swelling	❍ breast pain/lump	❍ dizziness
❍ cold extremities	❍ cramps	❍ loss of sleep
❍ blurred vision	❍ painful urination	❍ difficulty hearing
❍ vision problems	❍ bladder trouble	❍ ear pain
❍ difficulty breathing	❍ excessive urination	

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check ☑ all that apply*)

❍ falls/accidents	❍ head injuries	❍ fights
❍ sports injuries	❍ broken bones	❍ dislocations
❍ spinal tap	❍ surgery	❍ traction
❍ use(d) a cane or walker	❍ extensive dental work	❍ dental appliances
❍ knocked unconscious		

If yes to any of the above, please describe _____

_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

_____

Do any friends or relatives see chiropractors? ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you?

❍ no ❍ yes If yes, please tell us. _____

_____

_____

_____

Notes _____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care?

❍ Cash ❍ Check ❍ Credit Card # _____ Exp. _____

Insurance co. _____ Group Policy # _____

Address _____ Phone # _____

Insured's name _____

Relation _____ Insured's employer _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)