

Welcome

About You

Date: _____

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? _____

Employer Address _____

City _____ State _____ Zip Code _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name _____ Number of children? _____

Who may we thank for your referral? _____

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

EXERCISE

None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress

Packs/Day _____
Drinks/Week _____
Cups/Day _____
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 _____

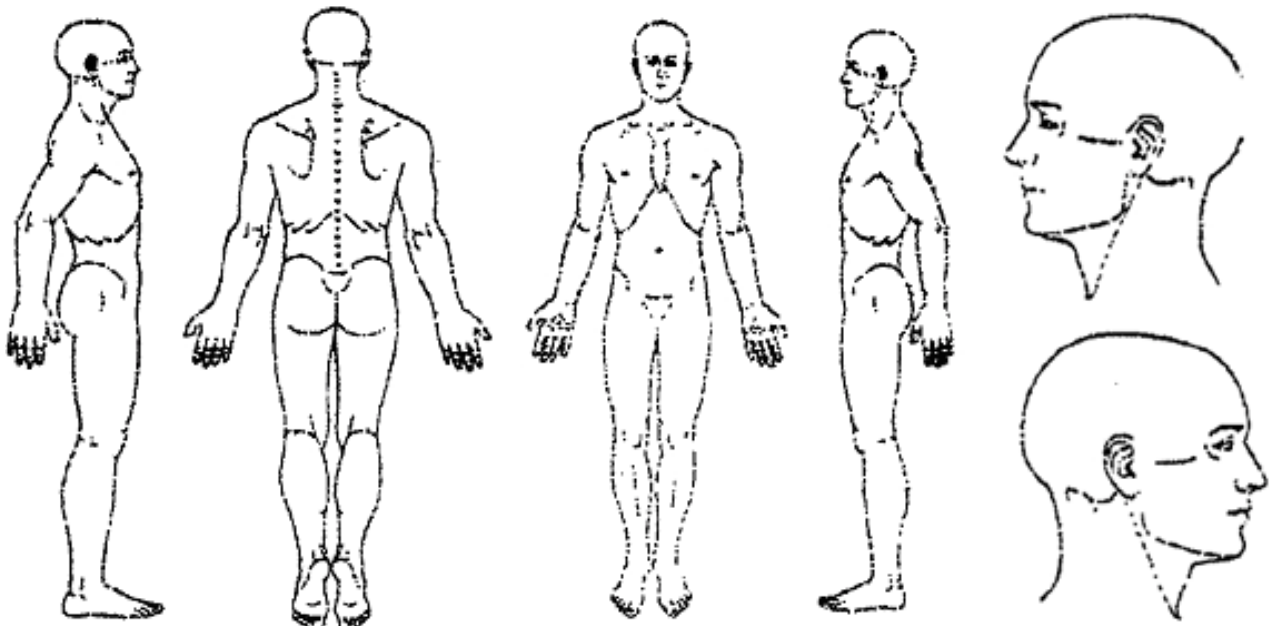
Other doctor(s) that treated you for this condition: _____

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

Type of pain:

- Sharp Dull Throbbing Aching Shooting
 Burning Numbness Tingling Stiffness Other

Place appropriate highlighted letters to mark the areas of discomfort



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 _____