Patient History (Please Print)

Date: _____

Name: _____ Email: _____ Phone: _____
Address: _____ City: _____ Zip: _____
Birth Date: ☐ Male ☐ Female Spouse's Name (Parent): _____
_____
#Children _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Occupation: _____ Social Security #: _____

How were you referred to our office? _____

Have you ever had chiropractic care before? _____ If yes, when? _____

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Complaint 2: _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Complaint 3: _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

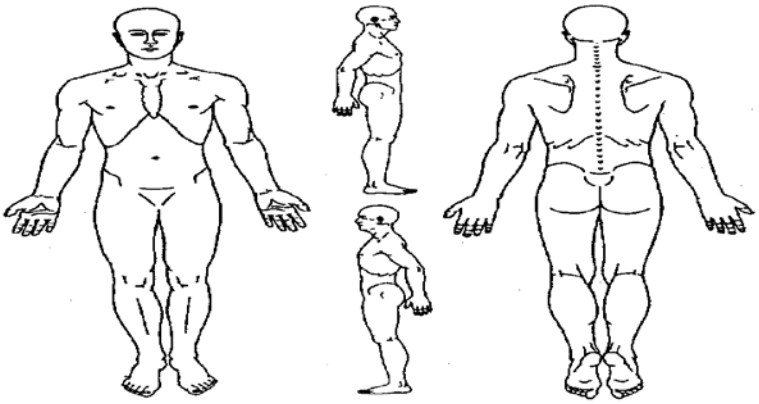
Does your condition interfere with your:

Work	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Sleep	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Daily Routine	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Recreation	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE

List other doctors consulted for condition:

1. _____ Address: _____
2. _____ Address: _____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas



Health History (Check if you have ever had any of the following:)

☐ Abdominal Aortic Aneurysm	☐ Fractures	☐ Osteoporosis
☐ AIDS/HIV	☐ Glaucoma	☐ Pacemaker
☐ Alcoholism	☐ Goiter	☐ Parkinson's
☐ Allergy Shots	☐ Gonorrhea	☐ Pinched Nerve
☐ Anemia	☐ Gout	☐ Pneumonia
☐ Anorexia	☐ Heart Disease	☐ Prostate Problems
☐ Appendicitis	☐ Hepatitis	☐ Psychiatric Care
☐ Arthritis	☐ Hernia	☐ Rheumatoid Arthritis
☐ Asthma	☐ Herniated Disc	☐ Stroke
☐ Bleeding Disorders	☐ Herpes	☐ Suicide Attempt
☐ Bulimia	☐ High Cholesterol	☐ Tuberculosis
☐ Cancer	☐ Kidney Disease	☐ Tumors/Growths
☐ Cataracts	☐ Kidney Stones	☐ Typhoid Fever
☐ Chemical Dependency	☐ Liver Disease	☐ Ulcers
☐ Chicken Pox	☐ Measles	☐ UTI
☐ Diabetes	☐ Miscarriage	☐ Vaginal Infections
☐ Eczema	☐ Mononucleosis	☐ Venereal Disease
☐ Emphysema	☐ Multiple Sclerosis	☐ Whooping Cough
☐ Epilepsy	☐ Mumps	☐ Other: _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

Is there anything else you think we should know about or that you would like to discuss? (Explain): _____

_____

_____

Patient's Signature: _____ **Date:** _____

Notice: Not all patients require x-rays to determine or verify a diagnosis, type and length of care. If your examination warrants x-ray analysis, the following office policy prevails:

1. All first visit charges are to be paid when services are rendered.

The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

*** If you have insurance please give the front desk your card***