Patient History (Please Print)

Date:_____

Name: _____ Email: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____ Hm Phone: _____

Birth Date: _____ ☐ Male ☐ Female Spouse's Name: _____

#Children _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation _____ Social Security# : _____ Wk Phone: _____

How were you referred to the Office? _____

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

List your chief complaint 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: _____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

Complaint 2: _____ For how long? _____

What originally caused this problem? _____

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

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

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

Complaint 3: _____ For how long? _____

What originally caused this problem? _____

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

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

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

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

Goals for Care :

_____

_____

_____

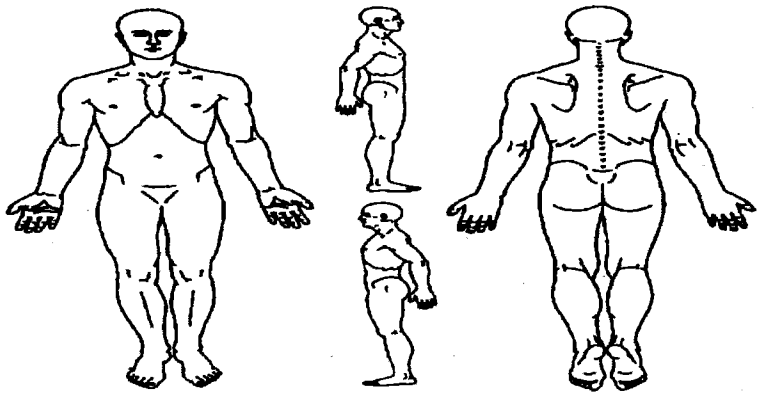
_____

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

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

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial condition: _____

Are you Pregnant: ☐ Yes ☐ No Due Date: _____

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: 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