

ABOUT THE PATIENT

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ DOB _____
Cell Phone _____
Social Security # _____
Driver's License # _____
Age _____ Gender M F # of Children _____
Employer _____
Work Address _____
Work Phone _____
Marital Status Married Single
E-Mail Address _____

REASON FOR VISIT

Please describe the purpose of this visit.

Is the purpose of this appointment related to...

- Job Sports Auto Fall
 Chronic Discomfort Home Injury Other

If job related, have you made a report of your accident to your employer? Yes No

When did this condition begin? _____

Has this condition..... gotten worse
 stayed constant comes and goes

Does this interfere with... work sleep
 daily routine other activities

Please explain _____

Has this condition occurred before? Yes No

Please explain _____

Have you seen other doctors for this condition?
 Yes No

Dr's Name(s) _____

Type of Treatment _____

Results _____

ABOUT THE SPOUSE OR PARENT

Name _____
Employer _____
Work Phone _____

Additional Emergency Contact Information

Name _____
Phone Number _____
Cell Phone _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that...

... Doctors of Chiropractic work with the nervous system? Yes No

... The nervous system controls all bodily functions and systems? Yes No

... Chiropractic is the largest natural healing profession in the world. Yes No

... If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

Has your child's spine been adjusted by a Chiropractor?
 Yes No

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before?
 Yes No

Reason for those visits? _____

Doctor's Name(s) _____

Approximate date of last visit _____

MEDICATIONS I NOW TAKE

- Nerve Pills
- Pain Killers (including Aspirin)
- Muscle Relaxers
- Blood Pressure Medicine
- Insulin
- Stimulants
- Blood Thinners
- Tranquilizers
- _____
- _____
- _____
- _____

SURGERIES

List body part operated on and date of surgery.

	Body Part	Date of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

HEALTH HABITS

No Yes

- Do you smoke ? No Yes _____ packs/day
- Do you drink alcohol? No Yes _____ drinks/day
- Do you drink coffee? No Yes _____ cups/day
- Do you use nutritional supplements? No Yes _____
- Do you exercise regularly? No Moderately Daily
- Do you wear... Heel Lifts Inner Soles
 Sole Lifts Arch Supports

FAMILY HEALTH HISTORY

Have any of your family members been diagnosed with any significant illness or diseases?

Has any member or your family suffered a stroke? Yes No

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | |
|--|---|--|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bowel/Bladder Control |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> HIV/Aids | |
| <input type="checkbox"/> Numbness or Pain in Arms/Legs/Hands | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Chemotherapy | |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psychiatric Problems | |

For Women:

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Are you taking birth control? Yes No
- Do you experience painful periods? Yes No
- Do you have irregular cycles? Yes No
- Do you have breast implants? Yes No