



Please complete the following information:

Patient's Name _____ Date: _____

How did you hear about this office? _____

Address: _____

City, State & Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: _____ Spouse's Name: _____ #Children: _____

Birth date: _____ Age _____

Social Security Number (optional): _____ Occupation: _____

Employer: _____ Employer's Address: _____

Insurance Company: _____

Family Medical Doctor: _____

Previous Chiropractor: _____

Are you seeking care for any of the following conditions?

- Headaches, Pulled Muscles, Sleeping problems, Irritable Bowel, Migraines, Leg pain/sciatica, Scoliosis, Hip Pain, Tense shoulders, Neck Pain, Mid-back pain, Low back pain, Lack of Energy, Numbness/tingling/burning, Dizziness/balance problems

Do these conditions interrupt? Family life, Career, Ability to exercise, Sleep, Social life

What methods have you tested? Exercises, Physical Therapy, Massage, Medication

What is your primary reason for seeking care in this office? _____

What brought this on/how long have you experienced this? _____

How would you describe the pain/discomfort (circle)?

Sharp spasms dull achy tension throbbing

What percentage of the time do you experience the most severe symptoms? _____

How would you rate the pain when at its worst? (Least) 0 1 2 3 4 5 6 7 8 9 10 (Most)

How would you rate the constant level of pain/discomfort? (Least) 0 1 2 3 4 5 6 7 8 9 10 (Most)

Activities or movements which are painful to perform:

- Sitting, Standing, Walking, Bending, Lying Down

Is this condition worse (circle): First thing in the morning Midday Afternoon Evening

List all accidents/traumas: _____

List any surgeries: _____

List medications: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraines | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteopenia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Herniated Disk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Warfarin/ Coumadin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Other _____

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking Packs/Day _____
- Alcohol Drinks/Week _____
- Coffee/Caffeine Cups/Day _____
- High Stress Level

Reason _____