WELCOME

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____
First Middle Initial Last

Address _____ City _____ State _____ Zip_____

Sex: Female Male Birthdate _____ E-mail _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Do you prefer to receive calls at: Home Work Cell No Preference

Employer _____ Occupation _____

Spouse or parent's name _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (_____)_____

CONFIDENTIAL

Symptoms

Reason for visit_____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain (1, mild pain or discomfort to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition: _____

Health History

Circle only those conditions which are applicable:

AIDS/HIV	Cataracts	Hepatitis	Osteoporosis	Suicide Attempt
Alcoholism	Chemical Dependency	Hernia	Pacemaker	Thyroid Problems
Allergy Shots	Chicken Pox	Herniated Disc	Parkinson's Disease	Tonsillitis
Anemia	Depression	Herpes	Pinched Nerve	Tuberculosis
Anorexia	Diabetes	High Cholesterol	Pneumonia	Tumors, Growths
Appendicitis	Emphysema	Kidney Disease	Polio	Typhoid Fever
Arthritis	Epilepsy	Liver Disease	Prostate Problems	Ulcers
Asthma	Fractures	Measles	Prosthesis	Vaginal infections
Bleeding Disorders	Glaucoma	Migraine Headaches	Psychiatric Care	Venereal Disease
Breast Lump	Goiter	Miscarriage	Rheumatoid Arthritis	Whooping Cough
Bronchitis	Gonorrhea	Mononucleosis	Rheumatic Fever	Other _____
Bulimia	Gout	Multiple Sclerosis	Scarlet Fever	
Cancer	Heart Disease	Mumps	Stroke	

Date of last primary care visit and/or other exams _____

(Women) Are you pregnant? Yes No Nursing? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy
What do your daily work habits include? (ex. sitting, standing, light labor, heavy labor, computer work)
_____
_____
What vitamins do you currently take? _____
What kind of other nutritional supplements do you take (if any)? _____
Do you smoke? No Yes How much per day? _____
How much liquor do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____
How much water do you consume? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I understand that I am financially responsible for all charges.

_____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____
Please print name of Patient, Parent or Personal Representative Relationship to Patient