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 _____

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

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 _____

_____

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 ?	☐	☐ _____ packs/day
Do you drink alcohol?	☐	☐ _____ drinks/day
Do you drink coffee?	☐	☐ _____ cups/day
Do you use nutritional supplements?	☐	☐ _____
Do you exercise regularly?	☐ No	☐ Moderatly ☐ 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.

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

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

Date: _____ Patient Signature: X _____