

Today's Date _____

Information About You

Account Number* _____ Birthday _____ Sex *M/ F* SSN _____

Last Name _____ First Name _____ Middle Initial _____

Marital Status: *S M D W* Occupation _____ Nickname _____

Address _____ Email _____

Address II _____ Phone H _____

City _____ Phone W _____

State _____ ZIP _____ Phone C _____

Referred By _____

Emergency Contact Name _____ Phone Number: _____

Number of Children _____ Names and Ages _____

Method of Payment: *Insurance, Self Pay, Care Credit, Med-pay, Other* _____

Have you ever had chiropractic care before? _____

For what problem and were the results satisfactory? _____

When is the last time you had x-rays? _____ Females: Are you pregnant? Y/ N/ I don't know

Any Surgeries	Trauma History	Social History	Diet History	Exercise	Current Meds
_____	Car Accidents	Drugs	Do you take Supplements?	Do you exercise?	_____
Implants	_____	_____	_____	What kind?	_____
_____	Serious Illnesses	Smoker Y/ N	Vitamins	How Often?	_____
Broken Bones	_____	Caffeine Y/ N	_____	Other Hobbies	_____
_____	_____	Alcohol Y/ N	Other	_____	_____
_____	_____	_____	_____	_____	_____

Family History: Did your mother or father have any of the following:
High blood pressure, Heart Attack, Emphysema, Seizures– Convulsions, Asthma, Diabetes, Kidney disease, pace maker, ulcers, digestive trouble, stroke, arthritis, Mental illness, thyroid, Cancer, Osteoporosis
Anything else you would like to discuss with us or let us know? _____

Initials _____

**Please Fill Out the Information Below, and circle all that apply to the problems you experience
(If you need help please ask the front desk)**

Main Health Concern 1)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating,			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious	Muscle Spasms Headach Tension Tingling	burning, Migraine, tension, hormonal, sinus, Other					

Main Health Concern 2)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating,			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious Other_____	Muscle Spasms Headach Tension Tingling	burning, Migraine, tension, hormonal, sinus, Other					

Main Health Concern 3)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating,			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious Other_____	Muscle Spasms Headach Tension Tingling	burning, Migraine, tension, hormonal, sinus, Other					

Activities of Daily Living: Circle which of the following are affected from your health issues and rate their severity.

- | | | |
|-------------------------------|------------------------------------|----------------------------------|
| Walking- Pain /10 ___% Ltd | Bending - Pain /10 ___% Ltd | Sitting - Pain /10 ___% Ltd |
| Standing - Pain /10 ___% Ltd | Sleeping - Pain /10 ___% Ltd | Lifting - Pain /10 ___% Ltd |
| Pushing - Pain /10 ___% Ltd | Driving - Pain /10 ___% Ltd | Dressing - Pain /10 ___% Ltd |
| Reading - Pain /10 ___% Ltd | Watching TV- Pain /10 ___% Ltd | Doing Chores - Pain /10 ___% Ltd |
| Gardening - Pain /10 ___% Ltd | Playing Sports - Pain /10 ___% Ltd | Working - Pain /10 ___% Ltd |
| Dancing - Pain /10 ___% Ltd | Sit to Stand - Pain /10 ___% Ltd | Rolling over - Pain /10 ___% Ltd |

Other Conditions: Please indicate with the letter **N** if you have these conditions now (within the past 6 months) or **P** if you ever had this conditions in the past.

- | | | | | |
|---------------|----------------------|-------------------|------------------------|----------------------|
| Headaches | Freq Loss of Balance | Arthritis | Upset Stomach | Shortness of Breath |
| Neck Pain | Loss of Smell | Feet Cold | Dry Skin | Depression |
| Stiff Neck | Loss of Taste | Hands Cold | High Blood Pressure | Difficulty Urinating |
| Wrist Pain | Ears Ring | Leg Cramps | High Cholesterol | Fatigue |
| Irritability | Sinus Problems | Hemorrhoids | Hard to Loose Weight | Numbness in Toes |
| Constipation | Diarrhea | Gall Bladder Pain | Cold/ Heat Intolerance | _____ |
| Low Back Pain | Chest Pains | Tension | Pins & Needles in Arms | _____ |
| Knee Pain | Foot Pain | Swelling Joints | Shoulder Pain | _____ |