ABOUT YOU

Today's Date: _____/_____/______

Name: _________________________________ What do you preferred to be called: __________________

Birthdate: _____/_____/______ Age: ______ ❑ Male ❑ Female

Home Address: ____________________________________ Home Phone: _________________________

____ Cell Phone: ___________________________

City State Zip

Email Address: _____________________________________ Facebook: ____________________________

Referred by: _______________________________________

Employer Name and Address: ____

____

Occupation: _______________________________________ Work Phone: __________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ___________________________________

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, please explain: ____

The reason for this visit is a result of:

❑ Work ❑ Sports ❑ Auto ❑ Trauma ❑ Chronic

Explain what happened: ____

____

Please describe the pain and its location: ____

____

When did condition begin? _____/_____/______

Is the condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine

If so, please explain: ____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: ____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? ____

Please continue on back →

IN CASE OF EMERGENCY

Who should we contact? ____________________________ Relation: ____________________________

Phone #: ____

Who is your Medical Doctor? _________________________ Phone #: _____________________________

HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers ❑ Muscle relaxers

❑ Stimulants ❑ Blood thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ________________________________

Have you ever had any of the following diseases/medical condition(s)?

- ☐ Heart attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ HIV/Aids
- ☐ Frequent Neck Pain
- ☐ High/Low Blood Pressure
- ☐ Severe/Frequent Headaches
- ☐ Fainting/Seizures/Epilepsy
- ☐ Diabetes/Tuberculosis
- ☐ Lower Back Problems
- ☐ Heart Surgery/Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Venereal Disease
- ☐ Shingles
- ☐ Emphysema/Glaucoma
- ☐ Psychiatric Problems
- ☐ Kidney Problems
- ☐ Sinus Problems
- ☐ Difficulty Breathing
- ☐ Artificial Joints
- ☐ Heart Murmur
- ☐ Artificial Valves
- ☐ Hepatitis
- ☐ Cancer
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Ulcers/Colitis
- ☐ Asthma
- ☐ Chemotherapy
- ☐ Arthritis

Please list any other serious medical condition(s) you have or ever had: ________________________________

____

Please list anything that you may be allergic to: ____

List previous surgeries/treatments with dates: ____

____

List any **past** serious accidents with dates: ____

Family Health History: ____

Do you smoke? ❑ Yes ❑ No How much? _____________________ How Long? _____________________

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? _______________ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No Are you pregnant? ❑ No ❑ Yes/How long? ______

Nursing? ❑ Yes ❑ No

- We invite you to discuss any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information requir3ed to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

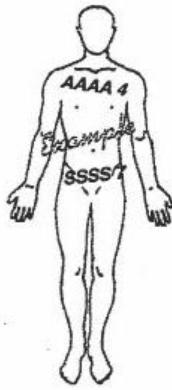
Signature: ____ **Date:** _____/_____/_____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

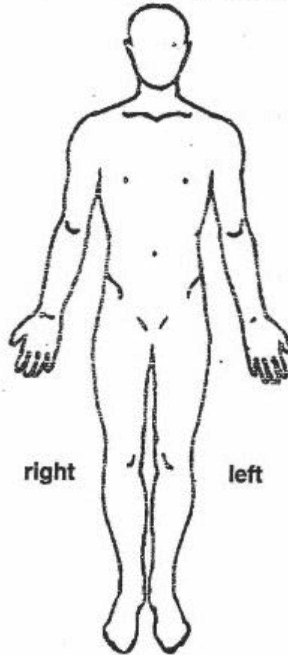
Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

⬭ Circle any area of pain not represented by a symbol.



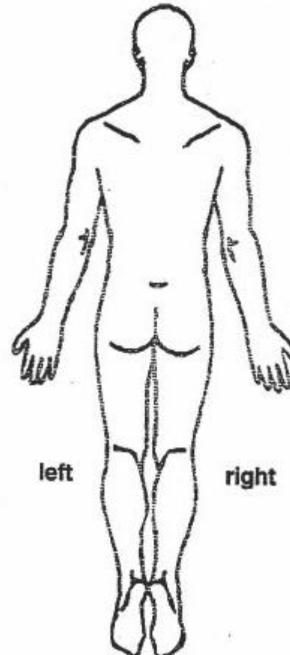
Example

Right



right left

Front



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Back

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ADDITIONAL COMMENTS

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