

Welcome

Section 1 About You...

Name: _____ What you prefer to be called: _____

male female Birthdate: ____/____/____ Age: _____ Marital Status: Single Married
Divorced Widowed

Home Phone #: _____ Cell Phone #: _____ E-Mail: _____

Address: _____
Street Number or Name City State Zip

Occupation: _____ Work Phone #: _____

Employer's Name & Address: _____
Name Street Number City State Zip

Spouse's Name: _____ Children: _____

Whom may we thank for referring you to this office? _____

Have you ever been to a Chiropractor before? If so, when? _____

Was your care geared toward treating a particular problem, or were you under maintenance care? _____

If the person seeking care is a minor or dependent, please provide the names of parents/guardians:

Parent/Guardian Names	Address
Home Phone	Cell Phone
Work Phone	E-mail

Section 2 Reason For Your Visit...

Do you currently have any symptoms? If so, what are they and how are they affecting your life? _____

If you have symptoms, when did they begin: _____ Are they getting worse? _____

Have you had the same or similar symptoms/condition in the past? When? _____

Are you currently under any Doctor's care? _____

Is your visit today related to: Work Sports Auto Accident Other: _____

If this is work related, did you report it to your employer? _____ Date of accident/injury: _____

Section 3 Your Health History...

Are you taking any of the following medications? List names of all drugs you are taking in the space provided.

- Nerve pills Pain killers Muscle Relaxers Antidepressants Anti-inflammatory. Insulin
 Blood Thinners Aspirin Other(s) _____

Do you take any vitamin or mineral supplements? _____

Have you ever had any of the following diseases/medical conditions?

- | | | |
|---|-----------------------------|----------------------------|
| Y N Heart Attack or any heart condition/symptoms:_____ | | |
| Y N Hepatitis | Y N Anemia | Y N Sports Injuries |
| Y N Alcohol/Drug Abuse | Y N Venereal Disease (STD) | Y N Neck Pain |
| Y N HIV + / AIDS | Y N Cancer | Y N Hyper/Hypothyroid |
| Y N Emphysema/TB | Y N High/Low Blood Pressure | Y N Ulcers/Colitis/IBS |
| Y N Diabetes/Glaucoma | Y N Difficulty Breathing | Y N GERD/Acid Reflux |
| Y N Panic Attacks | Y N Asthma/Allergies | Y N Lower Back Pain |
| Y N Arthritis | Y N Sciatica | Y N Carpal Tunnel |
| Y N Chronic Fatigue/Fibromyalgia | Y N Psychiatric Problems | Y N Artificial Joints |
| Y N PMS/Menopausal Symptoms | Y N Insomnia | Y N Metal inside your body |
| Y N Headaches (circle those which apply) migraine tension severe frequent _____ | | |

Please list any other serious medical condition(s) you have ever had or have been treated for: _____

Please list anything (including foods) that you may be allergic to:_____

List any past accidents with dates:_____

Do you smoke? No Yes How much?_____ How Long?_____

Are you pregnant? No Yes/How long?_____ Nursing? Yes No

Are you taking hormones or Birth Control Pills?_____

When was the last time you really felt well?_____

- I understand all of the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office (Doctor) of *any* changes in my medical status.
- I authorize the staff and doctor of this office to perform any necessary services needed during diagnosis and treatment.

Signature:_____

Date:_____