

Date _____ (Please Print)

Name _____

Address _____ City _____

State _____ Zip _____ Home Phone _____

Work Phone _____ Cell Phone _____

Referred by _____ Birth date _____ Sex _____

Primary care physician's name _____

May we send your M.D. updates? yes ___ no ___

Marital status _____ Spouse's name _____

Names and ages of your children _____

If you have insurance, please give your card to the front desk chiropractic assistant to copy.

What are your health objectives in consulting our office? _____

What are your expectations of us? _____

What is your level of commitment to yourself, your health and well-being?
 Low 1 2 3 4 5 6 7 8 9 10 High

Who was the last doctor who created a health development plan for you? _____

When? _____

Social Security Number _____

Occupation _____ Employer _____

E-mail address _____

May we send you office newsletters? ___ Yes ___ No

Emergency contact _____ Relationship _____

Contact number _____

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health concerns you have about them:

Lifestyle Information

(0=none and 10=extreme)

Nutrition: Poor 1 2 3 4 5 6 7 8 9 10 Excellent Stress Level: Personal _____ Occupational _____

Do you exercise? ___ yes ___ no If yes, what method and how often? _____

How many 8 oz. glasses of water do you drink per day? 1 2 3 4 5 6 7 8 9 10+

How many hours of sleep do you get on average? _____ hours Position: ___ Back ___ Side ___ Stomach

Do you smoke? ___ Yes ___ No If yes, how much and how often? _____

Do you consume alcohol? ___ Yes ___ No If yes, how much and how often? _____

Do you consume caffeine? ___ Yes ___ No If yes, what, how much and how often? _____

Work Activity: _____ Sitting _____ Standing _____ Light labor _____ Heavy labor

Please check all of the following health concerns that you have experienced, even if you do not think that your answers relate to your present health concern:

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Seizures	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Mid back pain
<input type="checkbox"/> Weight change	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Strokes	<input type="checkbox"/> Low back pain
<input type="checkbox"/> Wears glasses/contacts	<input type="checkbox"/> Swelling of legs	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Bladder problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Weakened immune system
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression	<input type="checkbox"/> Fertility problems
<input type="checkbox"/> History of head injury	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Allergies	
<input type="checkbox"/> Loss of smell or taste	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Food intolerances	For women only:
<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bruising	<input type="checkbox"/> Breast lumps/pain
<input type="checkbox"/> TMJ	<input type="checkbox"/> Limb weakness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cramps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headache	<input type="checkbox"/> Cancer	<input type="checkbox"/> Irregular menstruation

Addressing the issues that brought you to the office

If you don't have any symptoms or complaints, and are here for wellness services, please check here ____ "Wish to have chiropractic wellness services" and skip to the next box. Others need to briefly describe the chief area(s) of complaint, including the effect it has had on your life.

Please describe the location and the symptoms (i.e. burning, aching, sharp, radiating, etc) of **problem #1**.

When did you first experience this problem? _____

How did this problem begin? _____

Please grade the intensity of the problem At best: 0 1 2 3 4 5 6 7 8 9 10 At worst: 0 1 2 3 4 5 6 7 8 9 10
(0=none and 10=extreme) (0=none and 10=extreme)

Since it started, is it ____ About the same ____ Getting better ____ Getting worse

What makes it worse? _____ What makes it better? _____

What have you tried to relieve this problem? (i.e. interventions, treatments, aspirin, medications, surgery)?

Please describe the location and symptoms of **problem #2**: _____

When did you first experience this problem? _____

How did this problem begin? _____

Please grade the intensity of the problem At best: 0 1 2 3 4 5 6 7 8 9 10 At worst: 0 1 2 3 4 5 6 7 8 9 10
(0=none and 10=extreme) (0=none and 10=extreme)

Since it started, is it ____ About the same ____ Getting better ____ Getting worse

What makes it worse? _____ What makes it better? _____

What have you tried to relieve this problem? (i.e interventions, treatments, aspirin, medications, surgery)?

What activities are you unable to do because of your condition(s)? _____

Is your current condition a result of ____ an auto accident? ____ a work related injury? Date of injury? _____

Have you had previous chiropractic care? Y N If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____ What was the duration of your care? _____

Please list any other problems or areas of concern: _____

What is your goal with your health concern(s)?

____ Temporary relief (help the symptom but do not fix the cause of the problem)

____ Maximum correction (correct the cause of the problem for maximum stability in the future)

Please list any medications you are taking:

Please list any supplements you are taking:

Injuries/Surgeries

Description

Date

Motor vehicle accidents _____

Falls/Sports injuries _____

Head injuries _____

Broken bones _____

Dislocations _____

Surgeries _____

Previous x-rays _____

All services rendered to me are my personal responsibility and I agree to make payment for these services to the chiropractor's office. I also understand that if I suspend or terminate my care any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account. I authorize the chiropractor to examine and begin care as deemed appropriate, and I give authority for these procedures to be performed. The amount paid to the chiropractor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the chiropractor's office and will remain there on file.

Patient's/Guardian's Signature: _____ Date: _____