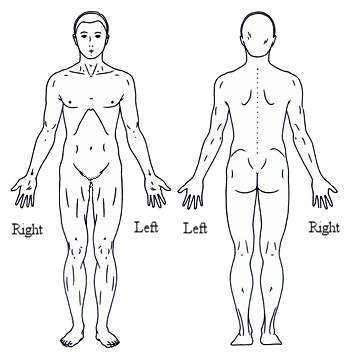
PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | Have you had previous chiropractic care? 🞏 Yes 🞏 No If yes, date of last adjustment: \_\_\_\_\_\_\_\_\_\_\_\_  Chiropractor contact info: Name/Address/Phone |
|  | What is your major complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Other complaints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | How long have you had this condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Have you had similar conditions in the past? 🞏 Yes 🞏 No |
|  | Is this condition getting progressively worse? 🞏 Yes 🞏 No 🞏 Constant 🞏 Comes and goes |
|  | Is this condition interfering with your: 🞏 Work 🞏 Sleep 🞏 Daily routine 🞏 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | How long has it been since you felt really good? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Other doctors who treated this condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Please list any surgical operations and years: |
|  | Drugs you now take: 🞏 Nerve pills 🞏 Pain killers 🞏 Muscle relaxants 🞏 “Pep” pills  🞏 Insulin 🞏 Birth control pills 🞏 Recreational drugs 🞏 Other medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Do you smoke? 🞏 Yes 🞏 No If yes, how many per day? \_\_\_\_\_\_\_ cigars / cigarettes / packs (*circle*) |
|  | Do you drink: 🞏 Coffee 🞏 Coffee (decaf) 🞏 Tea 🞏 Soda w/ caffeine # cups or cans per day: \_\_\_\_\_\_ |
|  | How much water do you drink each day? (do NOT count any other liquids – water only): |
|  | Age of your mattress? \_\_\_\_\_\_\_ 🞏 Comfortable 🞏 Not comfortable |
|  | Are you primarily 🞏 Right-handed 🞏 Left-handed |
|  | Are you wearing: 🞏 Heel lifts 🞏 Sole lifts 🞏 Inner soles 🞏 Arch supports |
|  | Date of last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Women Only: Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Do you feel there may be nutritional or external chemical/environmental factors affecting your health? 🞏 Yes 🞏 No  If yes, please explain: |
|  | Would you be interested in exploring these factors during the course of your treatment? 🞏 Yes 🞏 No |
|  | Do you feel there may be mental, emotional or stress-related factors affecting your health? 🞏 Yes 🞏 No  If yes, please explain: |
|  | Would you be interested in exploring these factors during the course of your treatment? 🞏 Yes 🞏 No |
|  | Have you been in an auto accident (s): 🞏 Past year 🞏 Past 5 years 🞏 Over 5 years 🞏 None |
|  | Have you had any other personal injury/accident(s): 🞏 Past year 🞏 Past 5 years 🞏 Over 5 years 🞏 None |
|  | *If you have been involved in an auto accident or have had any other accidents/personal injury, please complete the “Accident/Personal Injury” form.* |

*Please mark your areas of pain on the figures below:*

Please complete the information on this form. Your answers will assist in determining if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.



|  |  |
| --- | --- |
| Date: |  |
| Name: |  |
| Address: |  |
| City: |  |
| State: |  |
| Zip/ E-mail: |  |
| Home Phone: | |  |  |  | | --- | --- | --- | | Past | Present | Do you now or have you in the past had any of the following conditions:  (*check all boxes that apply*) | | | 🞏  🞏 | 🞏  🞏 | Loss of taste  Headaches | | 🞏  🞏 | 🞏  🞏 | Nervousness  Insomnia | | 🞏  🞏 | 🞏  🞏 | Dizziness  Loss of Smell | | 🞏  🞏 | 🞏  🞏 | Sinus trouble  Ear disorders | | 🞏  🞏 | 🞏  🞏 | Hay fever  Recurrent sore throats | | 🞏  🞏 | 🞏  🞏 | Asthma  Chronic cough | | 🞏  🞏 | 🞏  🞏 | Stomach tension  Digestive malfunction/reflux | | 🞏  🞏 | 🞏  🞏 | Nausea  Allergies | | 🞏  🞏 | 🞏  🞏 | Vomiting  Constipation | | 🞏  🞏 | 🞏  🞏 | Diarrhea  Abdominal pain | | 🞏  🞏 | 🞏  🞏 | Piles/hemorrhoids  Urinary disorders | | 🞏  🞏 | 🞏  🞏 | Bed wetting  Menstrual disorders | | 🞏  🞏 | 🞏  🞏 | Frigidity  Loss of potency | | 🞏  🞏 | 🞏  🞏 | Other sexual disorders  Chronic tension | | 🞏  🞏 | 🞏  🞏 | Chronic irritability  Chronic fatigue | | 🞏  🞏 | 🞏  🞏 | Sleeping problems  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Cell #/Email: |  |
| Date of Birth: |  |
| Age: |  |
| Employer: |  |
| Work Address: |  |
| City: |  |
| State: |  |
| Zip: |  |
| Work Phone: |  |
| Occupation: |  |
| Marital Status: |  |
| # of Children: |  |
| Spouse’s Name: |  |
| Referred by: |  |