Please complete the following information:

Patient's Name ____ Date: ____________________

How did you hear about this office? ____

Address: ____

City, State & Zip____

Home Phone: ____________________ Work Phone: _______________ Cell Phone: ________________

Email Address: ____

Marital Status: ________ Spouse's Name: ___________________ #Children: _________________________

Birth date: _______________________ Age_______________

Social Security Number (optional): ______________________ Occupation: ______________________

Employer: _______________________ Employer's Address: ___________________________________

Insurance Company: ____

Family Medical Doctor:____

Previous Chiropractor:____

Are you seeking care for any of the following conditions?

☐ Headaches ☐ Pulled Muscles ☐ Sleeping problems ☐ Irritable Bowel

☐ Migraines ☐ Leg pain/sciatica ☐ Scoliosis ☐ Hip Pain

☐ Tense shoulders ☐ Neck Pain ☐ Mid-back pain ☐ Low back pain

☐ Lack of Energy ☐ Numbness/tingling/burning ☐ Dizziness/balance problems

Do these conditions interrupt? ☐ Family life ☐ Career ☐ Ability to exercise ☐ Sleep ☐ Social life

What methods have you tested? ☐ Exercises ☐ Physical Therapy ☐ Massage ☐ Medication

What is your primary reason for seeking care in this office? _______________________________________

____

What brought this on/how long have you experienced this? _______________________________________

How would you describe the pain/discomfort (circle)?
Sharp spasms dull achy tension throbbing

What percentage of the time do you experience the most severe symptoms? _______________________

How would you rate the pain when at its worst? (Least) **0 1 2 3 4 5 6 7 8 9 10** (Most)

How would you rate the constant level of pain/discomfort? (Least) **0 1 2 3 4 5 6 7 8 9 10** (Most)

Activities or movements which are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Is this condition worse (circle): **First thing in the morning** **Midday** **Afternoon** **Evening**

List all accidents/traumas: ____

____

List any surgeries: ____

____

List medications: ____

____

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Measles	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Mumps	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Osteopenia	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Parkinson’s disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Goiter	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Herniated Disk	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Warfarin/ Coumadin	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Whooping cough	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No			

Other ____

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EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day__________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day__________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	

Reason________________________________