

Name _____ Date _____

Address _____ City/St/Zip _____

Home Phone _____ Date of Birth _____ Age _____ SS# _____

Height _____ Weight _____ Marital Status _____ Children/Ages _____

Employer _____ Type of Work _____

Work Phone _____ Email Address _____

Emergency Contact Name/Phone and Relationship _____

How did you hear about our office? _____

Do you have insurance? yes no If so, give card to office manager. If not, our Wellness Plans are for you--ask us

-----Current Health Condition-----

Purpose of this appointment _____

(if condition is work or auto accident related--please immediately inform office manager)

If traumatic—please describe _____

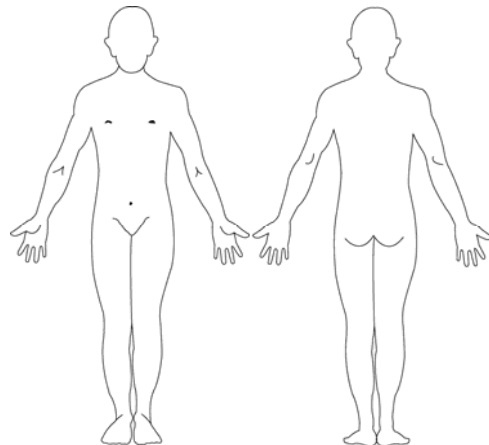
If Painful (Describe):
Where? For How Long? (Mark on Chart)

Dull, Aching, Stabbing, Throbbing?

Does it Radiate?

Any Numbness/Tingling?

Appeared Suddenly/Gradually?



Are you taking any medications and/or supplements? If so, What?

Is pain constant or does it come and go?

What makes pain better?

Worse?

Rate Pain 1=no pain 10=unbearable

Is pain worse in AM or PM?

As day progresses?

Is your range of motion restricted? yes no Where?

-----Why Chiropractic?-----

People go to chiropractors for a variety of different reasons and there are different levels of care. Please check the type of care desired so that we may guide you accordingly.

Stage 1 ___ Pain Relief: "Just get rid of the pain, Doc!" Relief is short term.

Stage 2 ___ Rehabilitation: "Get rid of the pain. Doc, but then fix the problem so it doesn't come back"

Stage 3 ___ Optimal Health: "Get rid of the pain, fix the problem and then put me on a preventative maintenance plan--including diet, exercise, stretching and chiropractic"

-----Health History-----

List and describe any significant accidents/surgeries/injuries:

Have you seen a chiropractor in the past and/or for this condition?

Did it help?

Have you seen any other health care professional for this condition? Did it help?

Please circle all that are relevant:

- | | | |
|----------------|--------------------|--------------------|
| Cancer | Musc. Dystrophy | Rheumatic Fever |
| Polio | Multiple Sclerosis | Scarlet Fever |
| TB | Convulsions | Nervousness |
| Hypertension | Epilepsy | Asthma |
| Heart Problems | Concussion | Digestive Problems |
| Diabetes | Dizziness | Sinus Problems |
| Hepatitis | Arthritis | Severe Backache |
| Broken Bones | Ear Infections | Anemia |

Are you allergic to any medication? _____

Are you pregnant? (for x-ray purposes) yes no Date of LMP _____