Patient Information | Today's Date:

Account # (Leave Blank)________________ Birth Date:____________ Sex: ☐ Male ☐ Female SSN_______________

Last Name ___________________ First Name ___________________ Middle Initial _________Nickname _____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation _________________________________

Address: ____ Email:____________________________________

2nd Address: ____ Phone (Home): ______________________________

City: ____ Phone (Work): _______________________________

State: _________ Zip __________________ Phone (Cell): _________________________________

Referred By __________________________________ Would you like to receive our newsletter (email)? ☐ Yes ☐ No

Emergency Contact Name _____________________________________ Phone Number: ______________________________

Number of Children _____ Names & Ages ____

Method of Payment: Insurance, Self Pay, Care Credit, Med-pay, Other ____

Have you ever had chiropractic care before? **Y / N** For what problem _____________ Were the results satisfactory? **Y / N**

When was the last time you had x-rays?__________________ Females: Are you pregnant? Yes / No / I don't know

The reason I am here is because I want: **(Please check all that apply)**

☐ Relief ☐ Corrective Care ☐ To be healthy ☐ I want the Doctor to recommend what is best for my health condition

Any Surgeries	Trauma History	Social History	Diet History	Exercise	Current Meds
____________	Car Accidents	Drugs	Do you take any Supplements?	Do You Exercise? ☐ Yes ☐ No	Please list your medications and dosage.
____________	____________	____________	____________	If so what kind?	____________
____________	____________	____________	____________	____________	____________
____________	____________	____________	____________	____________	____________
Implants	____________	Smoker ☐ Yes ☐ No	Do you take any Vitamins?	How Often?	____________
____________	____________		____________	____________	____________
____________	Serious Illnesses	Caffeine ☐ Yes ☐ No	____________	____________	____________
Broken Bones	____________		____________	____________	____________
____________	____________	Alcohol ☐ Yes ☐ No	Other	Other Hobbies	____________
____________	____________		____________	____________	____________

Family History:

Did your Mother or Father have any of the following:

☐ High Blood Pressure ☐ Heart Attack ☐ Emphysema ☐ Seizures – Convulsions

☐ Asthma ☐ Diabetes ☐ Kidney Disease ☐ Pace Maker

☐ Ulcers ☐ Digestive Troubles ☐ Stroke ☐ Arthritis

☐ Mental Illness ☐ Thyroid ☐ Cancer ☐ Osteoporosis

Please list any other health challenges / problems in your family history:

____

____

Patient Initials _____

Have you had or do you have any of the following symptoms which are or have been significant distress to you? Please indicate with the letter **N** if you have these conditions NOW (within the past 12 months) or **P** if you have ever had this conditions in the past (a year or longer). Leave blank if it has never been affected.

	Now N	Past P		Now N	Past P
Headaches	___	___	Frequent Loss of Balance	___	___
Neck Pain	___	___	Fainting	___	___
Stiff Neck	___	___	Loss of Smell	___	___
Sleeping	___	___	Problems / Loss of Taste	___	___
Back	___	___	Diarrhea with Pain	___	___
Nervousness	___	___	Feet Cold	___	___
Tension	___	___	Hands Cold	___	___
Irritability	___	___	Arthritis	___	___
Chest Pains	___	___	Muscle Spasms	___	___
Dizziness	___	___	Frequent Colds	___	___
Shoulder/Neck/Arm Pain	___	___	Stomach Upset	___	___
Pins & Needles in Arms	___	___	Constipation	___	___
Pins & Needles in Legs	___	___	Cold Sweats	___	___
Numbness in Fingers	___	___	Fever	___	___
Numbness in Toes	___	___	Sinus Problems	___	___
High Blood Pressure	___	___	Diabetes	___	___
Difficulty Urinating	___	___	Hemorrhoids	___	___
Allergies	___	___	Leg Cramps	___	___
Weakness in Arms	___	___	Colitis	___	___
Weakness in Legs	___	___	Gall Bladder	___	___
Shortness of Breath	___	___	Indigestion	___	___
Fatigue	___	___	Belching	___	___
Depression	___	___	Vomiting	___	___
Lights Bother Eyes	___	___	Shoulder Pain	___	___
Loss of Memory	___	___	Swelling Joints	___	___
Ears Ring	___	___	Knee Pain	___	___
Face Flushed	___	___	Hayfever	___	___
Buzzing in Ears	___	___	Menstrual Difficulties	___	___

Activities of Daily Living:

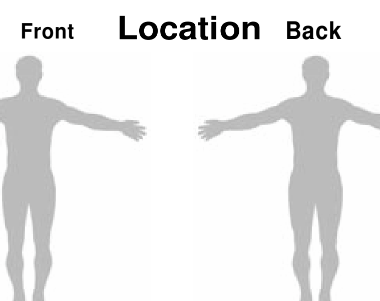
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Sleeping:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Running:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Climbing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Carrying:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Pushing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Reading:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Watching TV:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Doing Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Gardening:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Playing Sports:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Working:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Dancing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Change Positions: (Sitting to Standing)	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Rolling Over:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Other: ________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)

Please Fill Out the Information Below and Circle ALL that Apply to the Problems You Experience	**Patient Initials:**

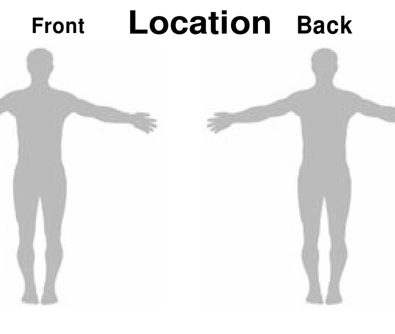
Main Health Concern 1) ______________________________

Onset Date	Type:	Quality	Front Location Back	Timing	Severity
________ Exacerbated ________	Pain, Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling, Weakness	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, migraine, tension,hormonal, sinus, Other		Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling

Main Health Concern 2) ______________________________

Onset Date	Type:	Quality	Front Location Back	Timing	Severity
________ Exacerbated ________	Pain, Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling, Weakness	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, migraine, tension,hormonal, sinus, Other		Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling

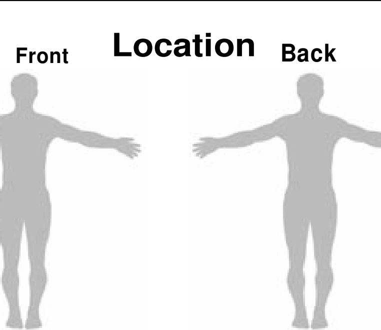
Main Health Concern 3) ______________________________

Onset Date	Type:	Quality	Front Location Back	Timing	Severity
________ Exacerbated ________	Pain, Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling, Weakness	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, migraine, tension,hormonal, sinus, Other		Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling

Main Health Concern 4) ______________________________

Onset Date	Type:	Quality	Front Location Back	Timing	Severity
________ Exacerbated ________	Pain, Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling, Weakness	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, migraine, tension,hormonal, sinus, Other		Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling

Main Health Concern 5) ______________________________

Onset Date	Type:	Quality	Front Location Back	Timing	Severity
________ Exacerbated ________	Pain, Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling, Weakness	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, migraine, tension,hormonal, sinus, Other		Constant, Frequent Intermitt Occasion Infrequent % Awake Time_____	Mild, Tolerable , Moderate , Severe, Disabling