PATIENT INFORMATION

NAME _____ ☐ M / ☐ F

ADDRESS _____ AGE _____ BIRTHDAY _____

CITY _____ STATE _____ ZIP _____ EMAIL: _____

PHONE: HOME _____ CELL _____ WORK _____

MARITAL STATUS _____ NUMBER & AGES OF CHILDREN _____

EMPLOYER _____TYPE OF WORK _____

HOW WERE YOUR REFERRED TO THIS OFFICE? _____

EMERGENCY CONTACT INFORMATION

NAME_____RELATIONSHIP _____

PHONE: HOME _____ WORK _____ CELL _____

PURPOSE OF THIS VISIT

IS IT RELATED TO? (PLEASE CIRCLE) AUTO ACCIDENT / WORK INJURY / NOT RELATED

REASON FOR THIS VISIT _____ WHEN DID IT BEGIN? _____

DESCRIBE THE CONDITION _____

HOW DID IT HAPPEN? _____

WHAT MAKES IT WORSE? _____ BETTER? _____

HAVE YOU HAD THIS CONDITION BEFORE? ☐ NO ☐ YES WHEN? _____

WHAT TREATMENT HAVE YOU TRIED? _____

HOW DID YOU RESPOND? _____

PRIOR EXPERIENCE WITH CHIROPRACTIC

HAVE YOU SEEN A CHIROPRACTOR BEFORE? ☐ NO ☐ YES WHEN WAS THE LAST TIME? _____

HOW DID YOU RESPOND? _____

ARE YOU AWARE OF ANY POOR POSTURAL HABITS? (DESCRIBE) _____

HEALTH HABITS

DO YOU:

SMOKE ? ☐ NO ☐ YES HOW MUCH? _____

DRINK WATER? ☐ NO ☐ YES HOW MUCH? _____

DRINK SODA? ☐ NO ☐ YES HOW MUCH? _____

DRINK COFFEE? ☐ NO ☐ YES HOW MUCH? _____

DRINK ALCOHOL? ☐ NO ☐ YES HOW MUCH? _____

TAKE SUPPLEMENTS (VITAMINS, MINERALS, HERBS, ETC.) _____

EXERCISE? HOW OFTEN & WHAT ACTIVITIES? _____

SLEEP ON YOUR ☐ STOMACH ☐ SIDE ☐ BACK? HOW MANY HOURS PER NIGHT (AVERAGE)? _____

PATIENT NAME _____ DATE_____

HEALTH HISTORY

PLEASE MARK ANYTHING YOU EXPERIENCE NOW OR IN THE PAST.

NECK RELATED:

- ☐ NECK PAIN / STIFFNESS
- ☐ HEADACHE
- ☐ NUMB / TINGLING IN ARMS / HANDS
- ☐ PAIN IN ARMS / HANDS
- ☐ COLDNESS IN HANDS
- ☐ WEAKNESS IN GRIP
- ☐ CARPAL TUNNEL
- ☐ FIBROMYALGIA
- ☐ LOW ENERGY / FATIGUE
- ☐ HEARING DISTURBANCES
- ☐ VISUAL DISTURBANCES
- ☐ DIZZINESS
- ☐ TMJ / JAW PAIN OR CLICKING
- ☐ ALLERGIES / HAY FEVER
- ☐ SINUSITIS
- ☐ RECURRENT COLDS / FLU
- ☐ HYPOTHYROID (LOW)

DOCTOR'S NOTES: _____

_____

_____

MID-BACK RELATED:

- ☐ PAIN BETWEEN SHOULDER BLADES
- ☐ MID-BACK PAIN / STIFFNESS
- ☐ PAIN IN RIBS / CHEST
- ☐ TENSION IN SHOULDERS
- ☐ INDIGESTION / HEARTBURN
- ☐ REFLUX
- ☐ ULCERS / GASTRITIS
- ☐ HEART MURMURS
- ☐ DIABETES
- ☐ HYPOGLYCEMIA
- ☐ HEART ATTACKS / ANGINA
- ☐ HEART PALPITATIONS
- ☐ RAPID HEART BEAT
- ☐ TIRED OR IRRITABLE AFTER EATING OR IF HAVEN'T EATEN FOR A WHILE
- ☐ NAUSEA
- ☐ SHORTNESS OF BREATH
- ☐ ASTHMA / WHEEZING
- ☐ LUNG INFECTIONS / BRONCHITIS
- ☐ PAIN ON DEEP BREATHING

DOCTOR'S NOTES: _____

_____

_____

LOW BACK RELATED:

- ☐ LOW BACK PAIN / STIFFNESS
- ☐ PAIN IN HIPS / LEGS / FEET
- ☐ NUMBNESS / TINGLING IN LEGS / FEET
- ☐ COLDNESS IN FEET
- ☐ WEAKNESS IN LEGS
- ☐ MENSTRUAL IRREGULARITIES / CRAMPING
- ☐ INJURIES IN HIPS / KNEES / ANKLES
- ☐ MUSCLE CRAMPS IN LEGS / FEET
- ☐ BLADDER INFECTIONS
- ☐ FREQUENT / DIFFICULTY URINATING
- ☐ SEXUAL DYSFUNCTION
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ IRRITABLE BOWEL
- ☐ OSTEOPOROSIS

DOCTOR'S NOTES: _____

_____

_____

ANY CODITION NOT LISTED ABOVE _____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING _____

LIST ALL SURGERIES AND DATES _____

LIST FALLS, ACCIDENTS, OR INJURIES AND DATES _____

FAMILY HISTORY

MOTHER'S SIDE OF FAMILY:	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER _____
FATHER'S SIDE OF FAMILY:	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER _____
BROTHERS/SISTERS:	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER _____