DR. USE ONLY
H.R.:_____
B.P.:___/___
Weight:_____

Patient Information and History

***Please fill out completely. If you have any questions please don't hesitate to ask.**
***Check "N/A" if Not Applicable**

Date: _____

Patient Name:_____
Address:_____ City: _____ State:_____ Zip:_____
Birthday: _____ Age:_____ ☐ Male ☐ Female
Occupation: _____ Employer: _____
Parent's Name (if a minor):_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Spouse's Name:_____ # of Children: _____ Name(s): _____
How were you **referred** to our office? ☐ Google ☐ Friend/Family Name_____

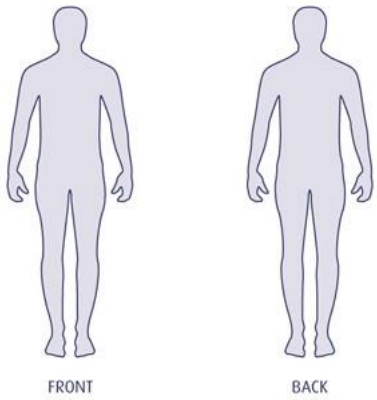
Contact Information

Cell Phone:_____ (Parent's Name & Cell if Minor)_____
Home Phone:_____
Work Phone:_____ Ext: _____
Email: _____
In case of emergency please contact:
Name:_____ Relationship: _____ Phone #:_____

Patient Condition

What is your major symptom/problem?_____ ☐ N/A
When did your symptoms begin?_____ ☐ N/A
Have you had this problem before? _____ ☐ N/A
Is your condition getting progressively worse? ☐ Yes ☐ No Is it: ☐ Constant ☐ Comes and goes ☐ N/A
How does it feel: ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching ☐ Stiff?
☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other _____ ☐ N/A

What makes the condition better?_____ ☐ N/A Worse?_____ ☐ N/A
Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation? ☐ Other _____ ☐ N/A
Painful movements/activities:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving
☐ Other _____ ☐ N/A
Circle below the severity of your pain:
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)



Please mark where it hurts

Health History

Primary Care Physician:_____Clinic's #:_____

Name & Location of Clinic:_____

What other treatments have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery ☐ None

Name of other doctors who have treated you for this condition: _____ ☐ N/A

Previous Chiropractic care? ☐ No ☐ Yes Dates:_____ ☐ Local ☐ Out of state _____

Date of last: Physical Exam _____ Spinal Exam_____ ☐ N/A

List any Medications you are taking: _____ ☐ None

Vitamins/Herbs/Minerals: _____ ☐ None

Check any of the following conditions you have/have had:

☐ Aids/HIV	☐ Earache	☐ Leg Pain
☐ Allergies	☐ Ear Ringing	☐ Low Back Pain
☐ Anxiety/Depression	☐ Epilepsy	☐ Prostate Problems
☐ Arm/Shoulder Pain	☐ Headaches	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Headaches – Migraine	☐ Sciatica
☐ Asthma	☐ Heart Disease	☐ Shingles
☐ Bladder Problems	☐ Hemorrhoids	☐ Sinus Infection
☐ Cancer	☐ Herniated Disk	☐ Stroke
☐ Chronic Fatigue	☐ High Blood Pressure	☐ Thyroid Problems
☐ Deafness	☐ Insomnia	☐ TMJ
☐ Diabetes	☐ Irregular Cycle	☐ Venereal Disease
☐ Digestion Problems	☐ Kidney Problem	☐ Vertigo/Dizziness

Stressors:

☐ Coffee/Caffeine Drinks	Cups/Day:_____
☐ Alcohol	Drinks/Week: _____
☐ High Stress Level	Reason: _____
☐ Smoking	Packs/Day: _____

Exercise:

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Have you had any:	**Description**	**Date**
Automobile Accidents	_____	_____
Surgeries	_____	_____
Broken Bones	_____	_____
Falls/Head Injuries	_____	_____
Other	_____	_____

Family History of Serious Illness: ☐ None

☐ Cancer: _____

☐ Diabetes: _____

☐ Heart: _____

☐ Autoimmune: _____

☐ Other: _____

What can we do to make you happier? _____

X I hereby authorize this office and its doctors to administer care to myself or my child as they deem necessary.

Date: _____ Signature: _____ Parent (if minor): _____