

(Please Print)

Date: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: H _____ W _____ C _____ E-Mail: _____

Social Security No.: _____ - _____ - _____ Birth Date: ____/____/____ Age: _____

Gender: Male Female Height: _____ Weight: _____

Name of Emergency Contact: _____ Phone Number: _____

Employer: _____ Insurance Company: _____

Name of Insured: _____ Date of Birth of Insured: ____/____/____

Employer of Insured: _____

Name of Spouse or Guardian: _____ Referred By: _____

Marital Status:

Married Domestic Partner Widowed Separated Divorced Single

Pregnant? (Female):

Yes No Unsure No. Of Children: _____

If you smoke cigarettes, how many do you smoke in an average day?

Do Not Smoke Less than ½ Pack ½ to 1 Pack 1 to 2 Packs More than 2 packs

If you drink alcohol, about how many drinks in an average day? (one drink is a bottle of beer, glass of wine, one cocktail, etc.)

Do not drink No more than 1 1 or 2 drinks 3-5 drinks 6-8 drinks More than 8 drinks

Recreational/Exercise:

Type: _____ Frequency: _____/week Duration: _____ Min/Hrs
 Type: _____ Frequency: _____/week Duration: _____ Min/Hrs
 Type: _____ Frequency: _____/week Duration: _____ Min/Hrs

Are you taking any medications? No Yes If yes, please identify: _____

Have you seen a Chiropractor before?: _____ Date of Last Visit: ____/____/____

Name of Primary Care Physician: _____

Primary Complaint/Reason for Visit: _____

Family History (1. Father, 2. Mother, 3. Sister, 4. Brother): (Please X if applicable and identify all family members that apply)

Cancer () # _____ Diabetes () # _____ Cardiac () # _____ TB () # _____
 CVA () # _____ BP () # _____ Epilepsy () # _____ Other () # _____



Name: _____

Mark the following conditions you have had or have now:

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Blood Vessel Disease |
| <input type="checkbox"/> Low Blood Sugar/Hypo-Glycemia | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Irregular Periods |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis or rheumatism |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Deafness or trouble hearing | <input type="checkbox"/> Sciatica or chronic back problems | <input type="checkbox"/> Hypertension or high blood Pressure |
| <input type="checkbox"/> Chronic lung disease (including Bronchitis or Emphysema) | <input type="checkbox"/> Blindness or trouble seeing, even when wearing glasses? | <input type="checkbox"/> Heart Attack or myocardial infarction |
| <input type="checkbox"/> Sugar Diabetes (diabetes mellitus) Type I | <input type="checkbox"/> Sugar Diabetes (diabetes mellitus) Type II | <input type="checkbox"/> Ulcer or gastrointestinal bleeding (not counting hemorrhoids) |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> OTHER _____ | |

How Long did you have pain before you first sought treatment?

- 1 week or less
 1 to 6 weeks
 > 6 weeks but < 3 months
 3 months to 1 year

How many times have you had this problem in the past?

- Never
 1 to 3 episodes
 4 or more episodes
 4 or more episodes

When did you first have these or similar symptoms?

- Never
 Less than 6 months
 6 months to 1 year ago
 More than a 1 year ago

Previous Treatment History for Primary Complaint

Date	Dr./Hospital	Treatment	Response (Better/Worse)	Treatment Duration	Test(s)	Test Result

Please List all surgeries, accidents or injuries:

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

Please sign name: _____

(If under 18 years of age, signature of parent or guardian)

Date: _____