

Personal Information

Please Print and fill out all information

Name: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip code: _____
E-mail address: _____ Home/Cell phone# _____ Work # _____
Who referred you to our office? _____ Are you a Veteran? _____
Marital Status: Single/Married/Divorce/Widow(er) Spouse's Name: _____ #of Children _____
Employer: _____ Job Duties: _____

Current and Past Health History

Have you ever been to a Chiropractor? No Yes Name of Chiropractor _____
Date of last Adjustment: _____ What type of problem were you experiencing? _____
How long were you under care? _____ Have you seen any Natural Health Care Providers? _____
Please list names and treatment received. _____
Do you have a Family Doctor? No Yes Name of Doctor: _____
Date of last visit: _____ Date of last exam: _____
Have you had surgery in the past 5 years? No Yes Date and type of surgery: _____
Other Surgery: (please list): _____
Please list medications you are currently taking _____
Please list any nutritional supplements you are taking _____
How many **ounces** of water do you currently drink each day? _____

Please take a moment to tell us a little about your general health history. Please mark any items that you have had or are currently experiencing.

Addiction/substance abuse	Yes	No	Dizziness	Yes	No	Osteoporosis	Yes	No
Allergies	Yes	No	Epilepsy	Yes	No	Ringing in Ears	Yes	No
Anxiety	Yes	No	Headaches	Yes	No	Scoliosis	Yes	No
Asthma	Yes	No	Heartburn /Reflux	Yes	No	Seizure Disorder	Yes	No
Auto Immune Disorders	Yes	No	Heart Condition	Yes	No	Sinus Trouble	Yes	No
Back pain	Yes	No	High Blood Pressure	Yes	No	Skin Conditions	Yes	No
Bladder Problems	Yes	No	Infertility	Yes	No	Spinal Disc Disease	Yes	No
Broken Bones	Yes	No	Kidney Disease	Yes	No	Thyroid Trouble	Yes	No
Cancer	Yes	No	Mental/Emotional Difficulty	Yes	No	Ulcer	Yes	No
Circulatory/Vascular Problems	Yes	No	Mood Swings	Yes	No	Urinary Difficulty	Yes	No
Depression	Yes	No	Migraine Headaches	Yes	No	Vertigo	Yes	No
Diarrhea	Yes	No	Multiple Sclerosis	Yes	No	Other		
Digestive Problems	Yes	No	Neck Pain	Yes	No			
Diverticulitis	Yes	No	Numbness or tingling	Yes	No			

Is there any significant Family Health History that we should be aware of? Yes No

Cancer _____ Heart disease _____ Auto Immune Disorders _____ Anxiety/depression _____ Emotional difficulty _____
Other: _____

Lifestyle and Social Questions

Alcohol Use: Yes No Amount per week? _____ Cigarettes or Vape: Amount per day ____ Former smoker? ____
 Caffeine use: Yes No Amount per day? _____ Non work-related exercise: Yes No Hours per week ____
 Are you Healthier today than you were 5 years ago? Yes No If not, what has changed? _____
 If nothing changes, do you think you will be healthier in 5 years? Yes No
 Do you want to improve your health and well being? Yes No

Addressing the Issues that Brought you to our Office Today

What brings you to our office today? (Circle) Wellness Physical Complaint Pregnancy

Please describe your concern: _____

How long has this been an issue? _____

Do you know what may have caused this problem? _____

How intense are your symptoms? (No symptom) 0 1 2 3 4 5 6 7 8 9 10 (Intense Symptoms)

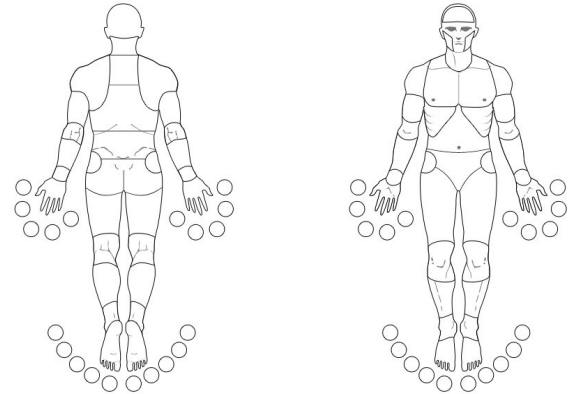
How often do you have these symptoms? Infrequent <25% Occasional 25-50% Frequent 51-75% Constant >75%

Other Health Concerns: _____

Please mark areas where you are experiencing pain or other symptoms.

What does it feel like?

- | | | |
|-----------|-----------|--------------|
| Dull | Burning | Swelling |
| Ache | Throbbing | Cramping |
| Sharp | Cramping | Nagging |
| Shooting | Travels | Tingling |
| Stiffness | Stabbing | Other: _____ |



Impact of your Symptoms on your Life:

The problem getting: Better _____ Worse _____ Staying about the same _____

When is it at its worst? Morning ___ Afternoon ___ Evening ___ At Night ___ Activities: Light ___ Moderate ___ Strenuous ___

What makes it better? _____

Chiropractic care Medication Rest Movement Stretching Laying down Standing Sitting

What makes it worse? _____

Daily Activities Standing Sitting Lifting Walking Bending Working Driving

What areas of your daily life do these symptoms or conditions impact? (circle)

Work	Relationships	Energy	Productivity
Exercise	Sleep	Attitude	Creativity
Recreation	Self-Care	Patience	Hobbies

Please rate the level of stress in your life (0= None, 10 very high) Occupation _____ Personal _____ Relationships _____

Please rate as Good, Fair, or Poor, your level of: Exercise _____ Diet _____ Sleep _____ General Health _____

If we find that you have a problem I can help you with, how committed are you to getting it corrected and improving your overall Health and State of well being? (Not committed) 0 1 2 3 4 5 6 7 8 9 10 (Very Committed)

The information provided is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____