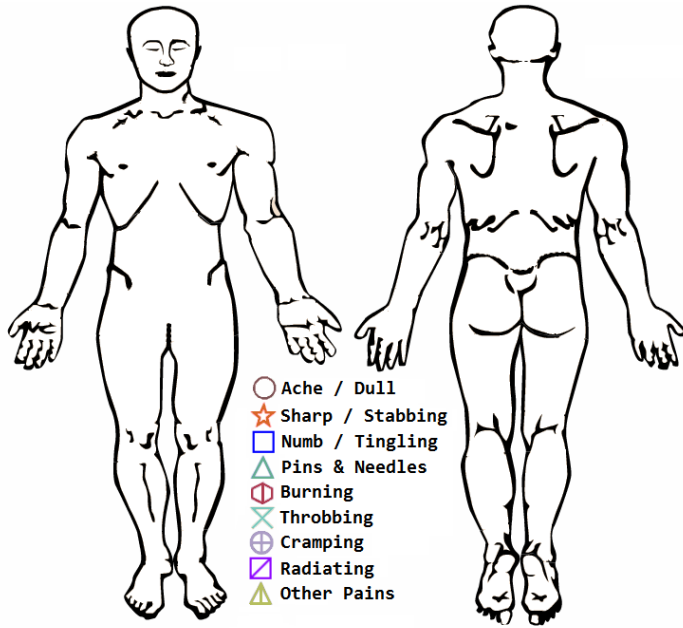


Phone:

Patient Information:

Date	SSN	Birthday
First Name	Middle Name	Last Name
Sex Male Female	Height	Weight
Married/Civil Union:	Spouse Name	# of Children
Home #	Cell #	Work #
Address		
City	State	Zip
Emergency Contact	Emergency Relation	Emergency Phone
Email		

Patient Symptoms:



Patient Social

Alcohol:	Daily	Weekly	Occasionally	Never	Caffeine:	Daily	Weekly	Occasionally	Never
Diet Food Products:	Daily	Weekly	Occasionally	Never	Drugs:	Daily	Weekly	Occasionally	Never
OTC Stimulants:	Daily	Weekly	Occasionally	Never	Exercise:	Daily	Weekly	Occasionally	Never
Homemade Food:	Daily	Weekly	Occasionally	Never	Processed:	Daily	Weekly	Occasionally	Never
Soft Drinks:	Daily	Weekly	Occasionally	Never	Tobacco:	Daily	Weekly	Occasionally	Never
Water:	Daily	Weekly	Occasionally	Never					

Chiropractic Experience:

Who referred you to our office:

Where did you hear about us? Newspaper Sign Yellow Pages Mailing Community Event Other

Have you been adjusted by a chiropractor before? Yes No If yes, Why?

Doctor's Name:

Approximate Date of Visit

Employer Information:

Employed: Employer Name

Employer Address:

Employer City: Employer State: Employer Zip:

Occupation: Work Supervisor: Supervisor #:

Work Duties:

Reason for this Visit:

Describe the reason for this visit?

When did this concern begin? Has this concern: Gotten Worse Stayed Constant Come and Gone

Does this concern interfere with: Work Sleep Daily Routine Other Activities

Briefly Explain:

Has this concern occurred before? Yes No

Briefly Explain:

Have you seen other doctor's for this concern? Yes No Doctor's name:

Type of Treatment:

Complaint Information:

Injury Occurred:	Work	Automobile	Third-Party	Other	Injury Date:	
Injury Origin:						
Desc Discomfort:						
Interfere w/ Activities:	Yes	No	Affected Sleep:	Yes	No	Frequency:
Missed Work:	Yes	No	Unable to Work from:	Unable to Work Until:		
Affected Appetite:	Yes	No	Explain:			
Reduced Work:	Yes	No	Explain:			
Does it Worsen:	Yes	No	Explain:			
Weather Affects it:	Yes	No	Explain:			
Aggravates Condition:						
Improves Condition:						
Received Treatment:	Yes	No	Explain:			
X-rays Taken:	Yes	No	Explain:			
Same Condition Before:	Yes	No	Date:	Practitioner:		

For Women Only:

Are you pregnant?	Yes	No	Are you taking birth control?	Yes	No	Do you have irregular cycles?	Yes	No
Are you nursing?	Yes	No	Do you experience painful periods?	Yes	No	Do you have breast implants?	Yes	No

Insurance Information:

Payment Name	Primary Phone #	Primary ID/Policy
Payment Address		
Payment City	Payment State	Payment Zip
Primary Group #	Primary Name	Primary DOB
Secondary Name	Secondary Phone #	Secondary ID/Policy
Secondary Address		
Secondary City	Secondary State	Secondary Zip
Secondary Group #	Secondary Name	Secondary DOB
Claim #	Claim Contact	Claim #
Attorney Name	Attorney Phone #	

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

I want the Doctor to select the type of care appropriate for my condition

Relief care: Symptomatic relief of pain or discomfort.

Corrective care: Correcting and relieving the cause of the problem as well as the symptom

Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Personal Health History

Last Physical Exam:		Primary Phys:		Phys Phone #:	
Phys City:		Phys State:		Phys Zip:	
Health Conditions:					
Previous Chiro Care:	Yes	No	Date:		Condition(s) treated:
Chance Pregnant:	Yes	No	Planning:	Yes	No
Medications:					
Supplements:					

Were you aware that...

Chiropractic is the largest natural healing profession in the world?	Yes	No	Doctor's of Chiropractic work with the nervous system?	Yes	No
The nervous system controls all bodily functions and systems?	Yes	No			

Personal Incident History:

Broken Bones:	Yes	No	Treatment:	Yes	No	Explain
Sprains/Strains:	Yes	No	Treatment:	Yes	No	Explain
Hospitalized:	Yes	No	Explain:			
Surgery:	Yes	No	Explain:			
Auto Accident:	Yes	No	Treatment:	Yes	No	Explain
Struck Unconscious:	Yes	No	Treatment:	Yes	No	Explain
Eating Disorder:	Yes	No	Explain:			
Stroke:	Yes	No	Explain:			

Health Checklist:

Allergies	Alcoholism	Anemia
Arteriosclerosis	Arthritis	Asthma
Back Pain	Breast Lump	Bronchitis
Bruise Easily	Cancer	Chest Pain
Cold Extremities	Constipation	Cramps
Depression	Diabetes	Digestion Problems
Dizziness	Excessive Menstruation	Eye Pain or Difficulties
Fatigue	Frequent Urination	Headache
Hemorrhoids	Venereal Disease	Hot Flashes
Irregular Heart Beat	Irregular Menstrual	Kidney Infection
Kidney Stones	Loss of Memory	Loss of Balance
Loss of Smell	Loss of Taste	Nosebleeds
Pacemaker	Polio	Poor Posture
Prostate Trouble	Sciatica	Shortness of Breath
High Blood Pressure	Sinus Infection	Insomnia
Spinal Curvatures	Stroke	Swelling of Ankles
Swollen Joints	Thyroid Condition	Tuberculosis
Ulcers	Varicose Veins	

Family Health History:

Family Health History

Signature

Date: