



Date: _____

Welcome to Our Office!

Our goal is to help you achieve better health. Please fill out the information below **completely** so that we may serve you to the best of our ability.

Name: _____ Preferred Name: _____			
Address: _____			
Street	City	State	Zip
Phone Number(s) _____ / _____ / _____			
Home	Cell	E-mail	E-Newsletter Y N
Birthdate: ____/____/____ Marital Status: S M D W Spouse's Name: _____			
Do you have any kids? Y/ N Names & Ages: _____			
How did you hear about us: _____			
Employer: _____ Work Phone: _____			
Brief job description: _____			

Have you ever been to a chiropractor? Y N Last adjustment: _____

Are you here for a specific problem or wellness? Please explain: _____

What do you expect to gain from chiropractic care? _____

Are you most interested in: _____ Correction of the Problem _____ Relief Only

If you chose Correction above, please rate your level of commitment (0-least,10- most): _____/10

Please describe the healthiest person you know: _____

Do you know that irritation of spinal nerves can cause the body to malfunction? Y N

Do you smoke? Y N Do you feel you eat properly? Y N Do you sleep well at night? Y N

How many 8 oz. cups of water do you drink on a daily basis? 1-3 4-6 7-10 >10

How important is your health to you? Whatever Somewhat, I don't have time Very Important

Please continue on other side



**Chiropractic
Health History**

Do you have, or have you had any of the following (please check all that apply)

- | | | | | | |
|------------------------------------|---------------------------------|--|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> mumps | <input type="checkbox"/> heart disease | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> smallpox | <input type="checkbox"/> influenza |
| <input type="checkbox"/> pleurisy | <input type="checkbox"/> polio | <input type="checkbox"/> chicken pox | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> whooping cough | <input type="checkbox"/> eczema | <input type="checkbox"/> measles |

If you have ever been diagnosed with another disease or condition, please describe: _____

- Do you use
- | | | | |
|----------------------------------|-------------------------------------|--|--------------------------------|
| <input type="checkbox"/> coffee | <input type="checkbox"/> tea | <input type="checkbox"/> artificial sweeteners | <input type="checkbox"/> sugar |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> cigarettes | <input type="checkbox"/> recreational drugs | |

Have you ever suffered from (please check all that apply for current and past conditions)

- | Current | Past | Current | Past | Current | Past |
|--------------------------|---|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> neck pain | <input type="checkbox"/> | <input type="checkbox"/> stuffy nose | <input type="checkbox"/> | <input type="checkbox"/> discolored urine |
| <input type="checkbox"/> | <input type="checkbox"/> low back pain | <input type="checkbox"/> | <input type="checkbox"/> allergies | <input type="checkbox"/> | <input type="checkbox"/> gas/bloating after meals |
| <input type="checkbox"/> | <input type="checkbox"/> headache/migraine | <input type="checkbox"/> | <input type="checkbox"/> fainting | <input type="checkbox"/> | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> vision problems | <input type="checkbox"/> | <input type="checkbox"/> weight loss | <input type="checkbox"/> | <input type="checkbox"/> colitis |
| <input type="checkbox"/> | <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> | <input type="checkbox"/> poor appetite | <input type="checkbox"/> | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> | <input type="checkbox"/> shoulder/arm pain | <input type="checkbox"/> | <input type="checkbox"/> excessive appetite | <input type="checkbox"/> | <input type="checkbox"/> black/bloody stool |
| <input type="checkbox"/> | <input type="checkbox"/> hand pain/tingling | <input type="checkbox"/> | <input type="checkbox"/> nervousness | <input type="checkbox"/> | <input type="checkbox"/> constipation |
| <input type="checkbox"/> | <input type="checkbox"/> leg pain/tingling | <input type="checkbox"/> | <input type="checkbox"/> confusion | <input type="checkbox"/> | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> jaw pain | <input type="checkbox"/> | <input type="checkbox"/> depression | <input type="checkbox"/> | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> | <input type="checkbox"/> chest pain | <input type="checkbox"/> | <input type="checkbox"/> dental problems | <input type="checkbox"/> | <input type="checkbox"/> stroke |
| <input type="checkbox"/> | <input type="checkbox"/> lung problems | <input type="checkbox"/> | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> heart problems | <input type="checkbox"/> | <input type="checkbox"/> frequent nausea | <input type="checkbox"/> | <input type="checkbox"/> tingling |
| <input type="checkbox"/> | <input type="checkbox"/> abnormal BP | <input type="checkbox"/> | <input type="checkbox"/> vomiting | <input type="checkbox"/> | <input type="checkbox"/> numbness |
| <input type="checkbox"/> | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> prostate problem | <input type="checkbox"/> | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> ankle swelling | <input type="checkbox"/> | <input type="checkbox"/> breast pain/lump | <input type="checkbox"/> | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> cold extremities | <input type="checkbox"/> | <input type="checkbox"/> cramps | <input type="checkbox"/> | <input type="checkbox"/> irregular menses |
| <input type="checkbox"/> | <input type="checkbox"/> blurred vision | <input type="checkbox"/> | <input type="checkbox"/> difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> loss of sleep |

Past injuries can affect present health (please check all that apply)

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> falls/accidents | <input type="checkbox"/> head injuries | <input type="checkbox"/> fights | <input type="checkbox"/> extensive dental work |
| <input type="checkbox"/> sports injuries | <input type="checkbox"/> broken bones | <input type="checkbox"/> traction | <input type="checkbox"/> knocked unconscious |
| <input type="checkbox"/> surgery | <input type="checkbox"/> spinal tap | <input type="checkbox"/> dislocations | <input type="checkbox"/> use (d) cane or walker |

If yes to above, please describe: _____

Do you have health insurance? Y N If yes, please bring your card to the receptionist.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____