



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 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					

Referral Information:

Referring Physician:	Referred Patient:	Referred by
Advertisement: Yes No	Advertisement:	
Referred Directory: Yes No	Referred Directory:	

Employer Information:

Employed:	Employer Name
Employer Address:	
Employer City:	Employer State: Employer Zip:
Occupation:	Work Supervisor: Supervisor #:
Work Duties:	

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:			
Pain level Rating - Scale 1 to 10:	At its best:		At its Worst:		Current Level:	
Same Condition Before:	Yes	No	Date:	Practitioner:		

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:					

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:

Alcoholism	Allergies	Anemia
Arteriosclerosis	Arthritis	Asthma
Autoimmune Disease	Back Pain	Bleeding Disorders
Breast Lump	Bronchitis	Bruise Easily
Cancer	Cataracts	Chest Pain
CHF	Cold Extremities	Constipation
COPD/emphysema	Cramps	CVA (stroke/TIA)
Dementia/Alzheimer's	Depression	Diabetes
Diagnosed emotional/mental	Digestion Problems	Dizziness
Epilepsy	Excessive Menstruation	Eye Pain or Difficulties
Fatigue	Frequent Urination	Gallbladder disease/stones
Glaucoma	Gout	Headache
Hemorrhoids	High Blood Pressure	Hot Flashes
Irregular Heart Beat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Liver disease/cirrhosis	Loss of Balance
Loss of Memory	Loss of Smell	Loss of Taste
Lung disease	Macular Degeneration	Migraines
Nosebleeds	Pacemaker	Parkinson's
Polio	Poor Posture	Prostate Trouble
Retinal Disease	Sciatica	Seizures
Shortness of Breath	Sinus Infection	Skin Sensitivity
Sleep Problems/Insomnia	Smoked	Spinal Curvatures
Stroke	Swelling of Ankles	Swollen Joints
Thyroid Condition	Tuberculosis	Ulcers
Varicose Veins	Venereal Disease	Other

Have you had any of these Cardiovascular Diseases? Please select all that apply.

Myocardial infarction	Hypertension	Hypercholesterolemia
Bypass surgery	Coronary artery disease	

Do you have Diabetes? If so what type?

Type I Type II Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

Ulcers	Reflux	IBS
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Family Health History:

Family Health History

Signature

Date: