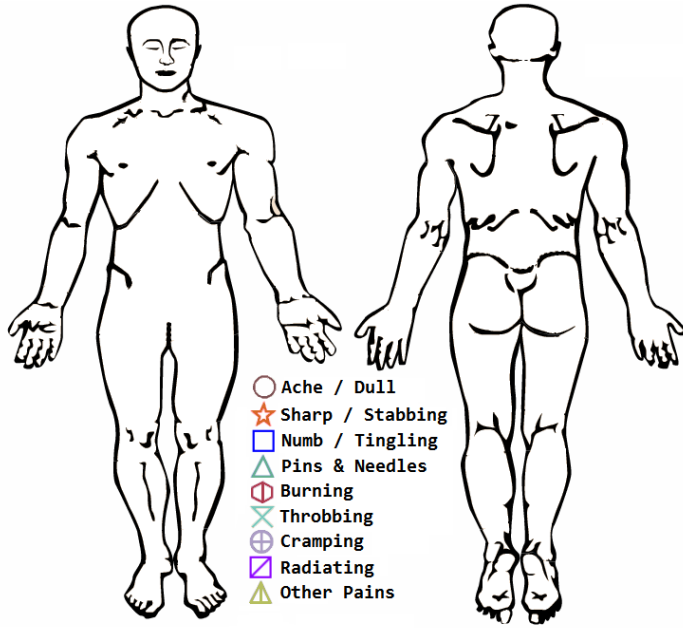


**\*\*PLEASE NOTE, THIS FORM CANNOT BE SUBMITTED BY A MOBILE DEVICE OR TABLET\*\***

### 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:



Ache / Dull  
 Sharp / Stabbing  
 Numb / Tingling  
 Pins & Needles  
 Burning  
 Throbbing  
 Cramping  
 Radiating  
 Other Pains

### Reason for this Visit:

Describe the reason for this visit?

Please briefly describe, including the impact it has had on your life.

Wellness	Sports	Auto	Fall	Home Injury	Job	Chronic Discomfort	Other
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Briefly Explain:

When did this concern begin? \_\_\_\_\_ Has this concern: \_\_\_\_\_

	Gotten Worse	Stayed Constant	Come and Gone
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Does this concern interfere with: \_\_\_\_\_

Work	Sleep	Daily Routine	Other Activities
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Briefly Explain:

Has this concern occurred before? \_\_\_\_\_

Yes	No
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Briefly Explain:

Have you seen other doctor's for this concern? \_\_\_\_\_

Yes	No	Doctor's name: _____
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Type of Treatment: \_\_\_\_\_

Results: \_\_\_\_\_

Good	Bad	Indifferent
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### Complaint Information:

Injury Occurred:	Work	Automobile	Third-Party	Other	Injury Date: _____
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Injury Origin: \_\_\_\_\_

Desc Discomfort: \_\_\_\_\_

Interfere w/ Activities:	Yes	No	Affected Sleep:	Yes	No	Frequency: _____
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Missed Work:	Yes	No	Unable to Work from: _____	Unable to Work Until: _____
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Affected Appetite: \_\_\_\_\_

Yes	No	Explain: _____
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Reduced Work: \_\_\_\_\_

Yes	No	Explain: _____
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Does it Worsen: \_\_\_\_\_

Yes	No	Explain: _____
-----	----	----------------

Weather Affects it: \_\_\_\_\_

Yes	No	Explain: _____
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Aggravates Condition: \_\_\_\_\_

Improves Condition: \_\_\_\_\_

Received Treatment: \_\_\_\_\_

Yes	No	Explain: _____
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X-rays Taken: \_\_\_\_\_

Yes	No	Explain: _____
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Pain level Rating - Scale 1 to 10: \_\_\_\_\_

At its best:	At its Worst:	Current Level: _____
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Same Condition Before: \_\_\_\_\_

Yes	No	Date: _____	Practitioner: _____
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### For Women Only:

Are you pregnant?	Yes	No	Are you taking birth control?	Yes	No	Do you take HRT?	Yes	No
Are you nursing?	Yes	No	Do you experience painful periods?	Yes	No	Do you have irregular cycles?	Yes	No
Do you perform a regular self breast examination?	Yes	No	Do you have breast implants?	Yes	No			
Do you take oral contraceptives?	Yes	No						
Date of last PAP/pelvic exam?			Date of last mammogram?			Date of Last Menstrual Period?		

## 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: