TREATING DOCTOR: _____

Date: _____

PERSONAL HISTORY

Name: _____ E-mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: ___/___/___ Age: _____ Sex: □ M or □ F Social Security Number: _____

Business Employer: _____ Type of Work: _____

Marital Status (Circle One): Married Single Widowed Divorced Separated Spouse's Name: _____

Name and Ages of Children: _____ Name of Health Insurance: _____

Is Policy under Spouse? □ Yes □ No If yes, Spouse Birth Date: ___/___/___ Spouse Employer: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Referred To This Office By: □Friend/Relative _____ □Yellow Pages □Insurance Comp. □Other _____

CURRENT HEALTH CONDITION

Reason For Visit: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? □Yes □No

Rate The Pain You Are Experiencing (0 no pain/10 most severe): _____ Is Pain Affecting Daily Activities? □Yes □No

Is The Pain: □ Constant □Comes and Goes □Other _____ Pain worse in : □AM □PM □Other _____

What Makes the Pain Worse? □Sitting □Bending □Standing □Lying Down □Walking □Weather □Other _____

What Makes the Pain Less? □Ice □Heat □Rest □Stretch □Over the Counter Med □Prescription Med □Other _____

Is Condition: □Job Related □Auto Accident □Home Injury □Fall □Other: _____

Date of Accident: _____ Have You Reported Your Accident To Your Employer: □Yes □No

Current Medications/Vitamins/Herbs: _____

Other Doctors Seen For This Condition: □Yes □No If yes, please list: _____

PAST HEALTH HISTORY

Previous Chiropractic Care: □None □ Doctor's Name & Approximate Date of Last Visit: _____

Have You Had Any X-rays Taken In The Past Two Years? □Yes □No If yes, where _____

Past Injuries Can Affect Current Health (Please Check and Describe)

Surgery/Operations: □Appendix □Tonsils □Gall Bladder □Hernia □Neck/Back Surgery □C-Section □Other: _____

Describe The Checked Above: _____

Accidents/Injuries: □Auto Accident □Sports Injury □Work Related □Fall on Ice □Fall from Height □Concussion/Unconscious
□Head Injury □Broken Bones □Dislocations □Other _____

Describe the Checked Above: _____

_____

FAMILY HEALTH HISTORY

Please Check and Indicate Family Members That Have/Had The Condition (include: mother, father, sibling, spouse, child, grandparent)

□Heart Disease _____ □Stroke _____

□Cancer _____ □Diabetes _____

□Lung Disease _____ □High Blood Pressure _____

□Other _____

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CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:

□ Pneumonia	□ Anemia	□ Chicken Pox	□ Kidney Disease	□ Epilepsy
□ Rheumatic Fever	□ Measles	□ Diabetes	□ Thyroid	□ Mental Disorders
□ Polio	□ Mumps	□ Cancer	□ Pleurisy	□ Migraine Headaches
□ Tuberculosis	□ Small Pox	□ Heart Disease	□ Arthritis	□ High Blood Pressure
□ Whooping Cough	□ AIDS/HIV	□ Liver Disease	□ High Cholesterol	□ Osteoporosis

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL
- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Joint Pain/Stiffness
- □ Walking Problems
- □ Difficulty Chewing/Clicking Jaw
- □ General Stiffness

NERVOUS SYSTEM
- □ Nervous
- □ Numbness
- □ Paralysis
- □ Dizziness
- □ Forgetfulness
- □ Confusion/Depression
- □ Fainting
- □ Convulsions
- □ Cold/Tingling Extremities
- □ Stress

GASTRO-INTESTINAL
- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Hemorrhoids
- □ Liver Problems
- □ Gall Bladder Problems
- □ Weight Trouble
- □ Abdominal Cramps
- □ Gas/Bloating After Meals
- □ Heart burn
- □ Black/Bloody Stool
- □ Colitis

GENITO- URINARY
- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored Urine

C-V-R
- □ Chest Pain
- □ Short Breath
- □ Blood Pressure Problems
- □ Irregular Heartbeat
- □ Heart Problems
- □ Lung Problem/Congestion
- □ Varicose Veins
- □ Ankle Swelling
- □ Stroke

EENT
- □ Vision Problems
- □ Dental Problems
- □ Sore Throat
- □ Ear Aches
- □ Hearing Difficulties
- □ Stuffed Nose

GENERAL
- □ Fatigue
- □ Allergies
- □ Loss of Sleep
- □ Fever
- □ Headache

MALES ONLY:
- □ Prostate Problem
- □ Sexual Dysfunction

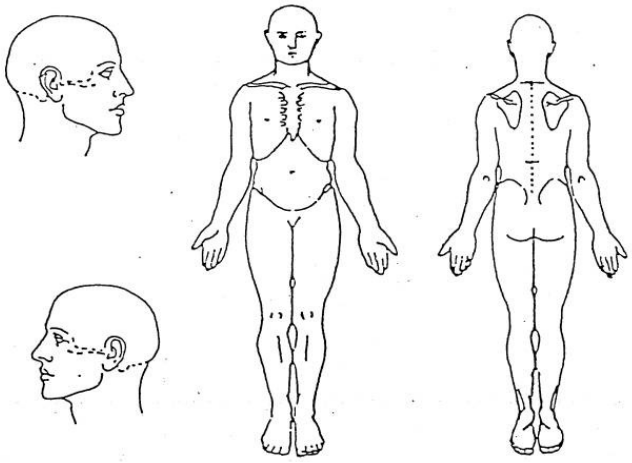
FEMALES ONLY:
- □ Vaginal Pain/Infection
- □ Breast Pain/Lumps
- □ Menstrual Cramps/Irregularities

When was your last period? _____

Are you pregnant? □ Yes □ No □ Unsure

If yes, due date: _____

Please MARK on the diagram below the area(s) of your discomfort



QUALITY OF PAIN (check all that apply)

□ Sharp □ Dull □ Achy □ Tight

□ Numb/Tingle □ Burning □ Shooting

HABITS
- □ Smoking _____ packs/day
- □ Alcohol _____ drinks/week
- □ Coffee/Caffeine _____ cups/day
- □ Water _____ cups/day
- □ High Stress—reason _____

SLEEP

Hours per night _____

Position: □Back □Side □Stomach □All

Number of Pillows _____

EXERCISE

□ None □ _____ days/week

WORK ACTIVITY

Years at Current Job _____

□ Sitting □ Standing

□ Light Labor □ Heavy Labor

INFORMED CONSENT: Certain types of cervical manipulations carry a slight risk of stroke. These are known as rotary breaks. This type of adjustment, using considerable rotation, is **NOT** used in this office.

NOTE: You (the patient) are liable for any charges deemed not medically necessary and/or for any balances not paid by your insurance company.

Patient Signature: _____ **Date:** _____

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