Patient Information

Name _____ Date _____ E-Mail _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Birthdate _____ Age _____ Sex _____

SS# _____ Status M S W D # of Children _____ Spouse's Name _____

Referred By _____ Occupation _____ Years Employed _____

Emergency Contact _____ Phone # _____ Relationship _____

Patient Condition

Reason for Visit _____

When did symptom(s) appear _____ Pain Scale 1(least pain) - 10(severe)_____

Type of Pain Sharp / Burning / Swelling / Tingling / Throbbing / Numb / Stiffness / Cramping / Aching

Activities/Movements that are painful to perform Sitting / Standing / Walking / Bending / Lying Down

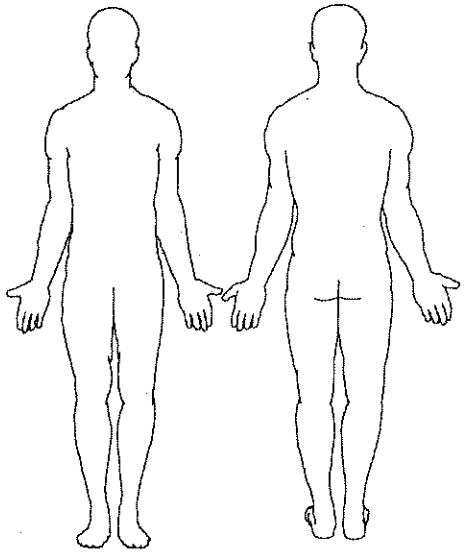
Are you currently taking any medications Yes / No If yes, Prescription? Non-Prescription?

List all medications currently taking _____

Other doctor(s) seen for this condition _____

Have you seen a chiropractor before? If so, how long ago?_____

Please mark on the picture where you have pain:



For Doctors Use Only

Health History

Do you have, or have you had any of the following?

AIDS/HIV	Yes	No	Goiter	Yes	No	Pneumonia	Yes	No
Alcoholism	Yes	No	Gonorrhea	Yes	No	Polio	Yes	No
Allergies	Yes	No	Gout	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Anorexia	Yes	No	Heart Attack	Yes	No	Seizures	Yes	No
Appendicitis	Yes	No	Hernia	Yes	No	STD	Yes	No
Arthritis	Yes	No	Herniated Disk	Yes	No	Smoking	Yes	No
Asthma	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Bowel/Bladder Abnormalities	Yes	No	High Blood Pressure	Yes	No	Suicide Attempt	Yes	No
Breast Lump	Yes	No	High Cholesterol	Yes	No	Thyroid Problems	Yes	No
Bronchitis	Yes	No	Hypoglycemia	Yes	No	Tonsillitis	Yes	No
Bulimia	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Liver Disease	Yes	No	Tumors	Yes	No
Cataracts	Yes	No	Measles	Yes	No	Ulcers	Yes	No
Chest Pain	Yes	No	Metal Implants	Yes	No	Genital Infections	Yes	No
Chicken Pox	Yes	No	Miscarriage	Yes	No	Whooping Cough	Yes	No
Diabetes	Yes	No	Mono	Yes	No	Pregnant	Yes	No
Dizziness	Yes	No	Mumps	Yes	No	If Yes, Due Date_____		
Emphysema	Yes	No	Osteoporosis	Yes	No	Special Diet	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No	If Yes, explain_____		
Fractures	Yes	No	Parkinson's	Yes	No			
Glaucoma	Yes	No	Pinched Nerve	Yes	No			

If answered YES to any of the above questions, please briefly explain: _____

_____

_____

Exercise None / Moderate / Daily / Heavy

Work Activity Sitting / Standing / Light Labor / Heavy Labor

Habits Smoking Packs/Day_____ Coffee/Caffeine Drinks Cups/Day_____

Alcohol Packs/Day_____ High Stress Level Reason_____

Please list and date any previous injuries, surgeries, and/or auto accidents

_____

_____

_____