Patient's Name: ______________________________

Gender: ______________________________

Date of Birth: ____________ Age: ______ Marital Status: __________

Street Address: ______________________________

____

City: ______________ State: ________ Zip code: ________

Occupation: ______________________________

Name of Employer/School: ______________________________

Email address: ______________________________

Best number to reach you at:

Home #: ______________ Cell #: ______________

Best way to contact you (phone, email or text): ______________

In case of emergency, contact:

Name: ______________ Phone #: ______________

Relationship: ______________________________

Current Health Conditions

Reason for visit:

____

When did it start? Be specific.

____

Have you received care for this problem? If yes, please explain:

____

____

How did the condition(s) first begin?

____

____

What makes the problem better?

____

____

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What makes it worse?

____

____

Is the condition getting worse, improving, or remaining the same?

____

____

Is the condition intermittent (off and on), constant, frequent or rare? ________________

Describe the pain (aching, sharp, numb, dull, burning, etc): ______________________

Rate your pain level (0 = no pain, 10 = severe pain): ___________________________

For Women Only:

Are you pregnant? ____

Due Date: ____

Are you currently nursing? ____

Your Health Goals

Describe your health goals:

____

____

Chiropractic History

What would you like to gain from chiropractic care? (Resolve condition, overall wellness, both)

____

Have you ever visited a chiropractor before? ______________________________

For what reason did you visit a chiropractor and did it help?

____

____

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Health History

Indicate if YOU or any IMMEDIATE FAMILY members have any of the following:

(check the conditions that apply)

- ☐ Rheumatoid Arthritis or Lupus
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke/TIA

If you selected yes to any of the previous, please specify who has/had the condition:

____

For each of the conditions listed below, please check the box if you have had the condition in the past or currently:

- ☐ Headaches
- ☐ Dizziness
- ☐ Asthma
- ☐ Neck Pain
- ☐ High or Low blood pressure
- ☐ Sinus Problems
- ☐ Upper back pain
- ☐ Heart Attack/Disease
- ☐ Diabetes
- ☐ Midback pain
- ☐ Knee pain
- ☐ Excessive thirst
- ☐ Low back pain
- ☐ Stroke
- ☐ Allergies
- ☐ Hand pain
- ☐ Loss of bladder control
- ☐ Depression/anxiety
- ☐ Upper leg pain
- ☐ Painful urination
- ☐ Lupus (SLE)
- ☐ Hip pain
- ☐ Bladder infection
- ☐ Epilepsy
- ☐ Knee pain
- ☐ Prostate problems
- ☐ Dermatitis/psoriasis/eczema
- ☐ Ankle/foot pain
- ☐ Ulcers
- ☐ Pregnancy
- ☐ Rheumatoid arthritis
- ☐ Cancer
- ☐ General fatigue
- ☐ Muscular incoordination
- ☐ Vision Problems
- ☐ Gallbladder Problems
- ☐ Loss of balance
- ☐ Ringing in the ears
- ☐ Sensitivity to light
- ☐ Loss of concentration
- ☐ Memory problems
- ☐ Cold hands/feet

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- ☐ Frequent urination
- ☐ Shoulder pain
- ☐ Angina
- ☐ Tobacco use
- ☐ Arm pain
- ☐ Kidney stones
- ☐ Drug/alcohol dependence
- ☐ Wrist pain
- ☐ Kidney disease
- ☐ Abnormal weight change
- ☐ Concussion
- ☐ Jaw/TMJ pain
- ☐ Loss of appetite
- ☐ Hormonal replacement
- ☐ Joint swelling
- ☐ Abdominal pain
- ☐ Birth control pills
- ☐ Arthritis
- ☐ Anemia
- ☐ Broken bones
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Thyroid problems
- ☐ Other:

Traumas: Physical Injury History

Have you ever had any significant falls, surgeries, accidents or injuries as an adult?

____

If yes, please explain:

____

____

Have you ever been hospitalized? If yes, why?

____

____

Notable childhood injuries?

____

____

Youth or college sports?

____

Describe any car accidents you've been in:

____

____

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Exercise Frequency (1-2x/week, 3-5x/week, daily or never): ______________________

What types of exercise do you perform? ______________________________________

How do you normally sleep? (back, side, stomach) _____________________________

How many hours of sleep do you get per night? _______________________________

Do you wake up refreshed? stiff/tired? _______________________________________

How many hours per day do you typically spend sitting? _________________________

Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each: (1=never, 5=high)

Alcohol	☐1	☐2	☐3	☐4	☐5
Water	☐1	☐2	☐3	☐4	☐5
Sugar	☐1	☐2	☐3	☐4	☐5
Caffeine	☐1	☐2	☐3	☐4	☐5
Processed Food	☐1	☐2	☐3	☐4	☐5
Artificial Sweeteners	☐1	☐2	☐3	☐4	☐5
Cigarettes/Tobacco	☐1	☐2	☐3	☐4	☐5
Recreational Drugs	☐1	☐2	☐3	☐4	☐5
Fast Food	☐1	☐2	☐3	☐4	☐5

Allergies (food, environmental, or drug): ______________________________________

Please list any drugs/medications/herbs/vitamins/supplements/other that you are taking, and why:

____

____

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Thoughts: Emotional Stress

Please rate your STRESS for each: (1=none, 5=high)

Home	☐1	☐2	☐3	☐4	☐5
Work	☐1	☐2	☐3	☐4	☐5
Money	☐1	☐2	☐3	☐4	☐5
Health	☐1	☐2	☐3	☐4	☐5
Family	☐1	☐2	☐3	☐4	☐5

Signature and Date

____
Signature of patient/guardian

____
Please print name of patient/guardian

____
Date