



Date _____

Whom may we thank for referring you: _____

Last Name: _____ First: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: _____ Age: _____

Email: _____ Phone: Cell _____ Home _____

Emergency Contact: _____ Phone: _____ Married: yes no Spouse's Name: _____

Are you pregnant? yes no If so, how far along are you? _____ Due Date: _____

Children's Names and Ages: _____

Have your children been under previous chiropractic care? yes no

Occupation: _____ Employer: _____ May we contact you at work? yes no Phone: _____

Prior Chiropractic Care:

Doctor's Name: _____ Clinic Name: _____ Phone: _____

For how long: _____ Results Achieved: Excellent Good Fair Poor

X-rays taken: yes no If so, when: _____ What areas: _____

Medical Doctor:

Doctor's Name: _____ Clinic Name: _____ Phone: _____

Doctor's Name: _____ Clinic Name: _____ Phone: _____

Other Healthcare Providers:

Doctor's Name: _____ Profession: _____ Phone: _____

Doctor's Name: _____ Profession: _____ Phone: _____

Reason for Visit:

The reason(s) that have prompted you to seek care today: _____

When did you first start noticing this? _____ Cause? _____

How often does this occur? _____

Is this interfering with: Work Sleep Routine Other _____

Other Doctors seen for this reason? _____

What medications are you taking? _____

Have you had surgery? yes no What? _____ When? _____

How would you rate your overall health?

Worst you have ever been _____ Best you have ever been

Please place an X on the line where you perceive you are overall.

Review of Systems: (Please mark all that are applicable.)

Neurological

- Allergies
- Anxiety
- Depression
- Dizziness
- Nervousness
- Numbness
- Loss of Sleep
- Pins & Needles

Digestive

- Excessive gas
- Colon Problems/IBS
- Constipation
- Diarrhea
- Hemorrhoids
- Gall Bladder/Liver Trouble
- Anorexia/Bulimia
- Ulcers

Eyes, Ears, Nose & Throat

- Ear Infection
- Eye Infection
- Sore Throat
- Sinus Infection
- Tonsillitis
- Buzzing Sound in Ears
- Ringing in Ears
- Hearing Loss

Muscle & Joint

- Arthritis
- Bursitis
- Foot/Ankle Pain
- Hip disorders
- Knee Pain
- Neck Pain
- Poor Posture
- Scoliosis
- TMJ Disorder
- Low Back Pain
- Shoulder Pain

Cardiovascular

- Chest Pain
- High Blood Pressure
- Low Blood Pressure
- Rapid Heartbeats
- High Cholesterol
- Poor Circulation
- Excessive Bruising
- Swelling of Ankles
- Abnormal Heartbeat
- Varicose Veins

Respiratory

- Asthma
- Apnea/Snoring
- Difficulty Breathing
- Pneumonia
- Chronic Cough

Genitourinary

- Bedwetting
- Infertility
- Kidney Infection
- Erectile Dysfunction
- Prostate Issues

Skin

- Psoriasis
- Dryness
- Eczema
- Rash
- Yeast/Fungus

Constitutional

- Fainting
- Fatigue
- Low Libido
- Poor Appetite
- Weakness

Female

- Irregular Cycle
- Painful Cycle
- Menopausal Yes No

Other:

- Acid Reflux
- AIDS
- Anemia
- Alcoholism
- Arnold Chiari
- Autism
- ADHD
- Cancer
- Diabetes
- Epilepsy
- Fibromyalgia
- Gout
- Glaucoma
- Heart Disease
- Multiple Sclerosis
- Herniated Disc
- Hepatitis
- Migraines
- Spine Degeneration
- Rheumatoid Arthritis
- Other _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

- Do you exercise regularly? yes no Do you drink? yes no
- Do you smoke? yes no Do you take supplements? yes no

YOUR GOALS FOR CARE:

- Feel better quickly/pain relief.
- Feel better and prevent its return.
- Have a healthier spine.
- I want optimum health and to live a healthier lifestyle.

We invite you to discuss with us any questions regarding our services. The best health services are based upon a friendly, mutual understanding between our team and yourself. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office.

Client's Signature _____ Date _____