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?____

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

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

Neurological
- Allergies
- Anxiety
- Depression
- Dizziness
- Nervousnes
- 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
- Ringing in Ears
- Hearing Loss
- Swelling of Ankles

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

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

Respiratory
- Asthma
- Apnea
- Difficulty Breathing
- Emphysema
- Chronic Cough

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

Skin
- Acne
- Dryness
- Eczema
- Rash
- Yeast/Fungus

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

Female
- Heavy Flow
- Irregular Cycle
- Painful Cycle
- Discharge
- Menopausal Yes No

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

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side					
Mother's Side					

Social History:

Do you exercise regularly? yes no

Do you smoke? yes no

Do you drink? yes no

Do you take supplements? yes no

YOUR GOALS FOR CARE:

- Feel better quickly/pain relief.
- Have a healthier spine.
- Feel better and prevent its return.
- 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 afriendly, 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______________