

ABOUT THE PATIENT

Name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Email Address: _____ (used to send exercises)
 Social Security #: _____ Birth Date: ___/___/____ Age: _____ Male: _____ Female: _____
 Marital Status: Married Single Divorced Separated Widowed # of Children: _____ Ages: _____
 Occupation: _____ Employer: _____
 Employer Address: _____ City: _____ State: _____ Zip: _____
 Spouse Name: _____ Contact Number: _____
 Whom may we thank for referring you to our office? _____
 Have you seen a Chiropractor before? Yes No Approximate Date of Last Visit _____
 Reason for those visits? _____ Doctor's Name _____

REASON FOR THIS VISIT? If you are experiencing any pain (neck, mid back, low back, etc) or other health problem list them here.

1. _____ How Long? _____ 2. _____ How Long? _____
 3. _____ How Long? _____ 4. _____ How Long? _____

If **job related**, have you reported this accident to your employer? Yes No N/A
 If related to a **car accident**, have you reported this injury to the insurance? Yes No N/A

YOUR HEALTH SUMMARY

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

<input type="checkbox"/> Neck/UB/MB/LB Pain	<input type="checkbox"/> Shoulder Pain L/R	<input type="checkbox"/> Heart	<input type="checkbox"/> Cold/Burning/Itchy
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Wrist Pain L/R	Palpitation/Murmur	Hands/Feet
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Asthma/Upper Resp.	<input type="checkbox"/> Pn, Numb, Ting, Wk to
<input type="checkbox"/> Fever	<input type="checkbox"/> Depression	Infection	Arms/Legs
<input type="checkbox"/> Sinus/Allergies	<input type="checkbox"/> Mood	<input type="checkbox"/> Heart Burn/Indigestion	<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Ear Infections	Swings/Irritability	<input type="checkbox"/> Ulcers/Acid Reflux	<input type="checkbox"/> Freq. Urination/Urinary
<input type="checkbox"/> Ringing/Buzzing in Ears	<input type="checkbox"/> Fatigue/Sleeping	<input type="checkbox"/> Stomach/Digestive	Infec.
<input type="checkbox"/> Pain Behind	Problems	Problems	<input type="checkbox"/> Cramping/Irregular
Eyes/Blurred Vision	<input type="checkbox"/> Chest Pain/Shortness	<input type="checkbox"/> Excess Gas	Periods
<input type="checkbox"/> Loss of Taste/Smell	of Breath	<input type="checkbox"/> Cramping in Arms/Legs	<input type="checkbox"/> Difficulty Getting
<input type="checkbox"/> Fainting/Loss of	<input type="checkbox"/> Cold Sweats/Hot	<input type="checkbox"/> Sciatica L/R	Pregnant/Impotence
Balance	Flashes	<input type="checkbox"/> Hip Pain L/R	
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Other: _____		

Please indicate/mark your problem areas on the diagram below:



