Patient Id# _____

(Please Print)

Patient History

Date: _____

Name: _____ Email: _____ Home Ph: _____
Work Ph: _____ Cell Ph: _____ Carrier: _____
Address, City, Zip: _____
Birth Date: _____ Age: ____ ☐ Male ☐ Female Spouse's Name (Parent): _____
Of Children: ____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Occupation: _____
Employed by: _____ Work Address: _____

How were you referred to our office? _____ **Social Security #:** _____

Have you ever had chiropractic care before? _____ If yes, when? _____

List your chief complaints in order of severity:
1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Rate the pain of your chief complaints on a scale from 0 to 10. (0 = No Pain, 10 = Severe Pain)
1. _____ 2. _____ 3. _____

List other doctors consulted for this condition:
1. _____ Address: _____
2. _____ Address: _____

Is this injury work related? _____ Have you reported it to your employer? _____

Is this injury related to an automobile accident? _____ If yes name YOUR:
Auto Ins. Co.: _____ Policy #: _____ Claim#: _____ Phone #: _____
Address: _____ Agent's Name: _____

Do you have any type of health insurance? _____ Company: _____
Address: _____ Policy #: _____

Are you covered under any other group or individual health policy through yourself or spouse? _____
If yes, Company Name: _____ Address: _____
Spouse's Social Security #: _____ Employer: _____
Address, City, State, Zip: _____

Notice: Not all patients require x-rays to determine or verify a diagnosis, type and length of care. If your examination warrants x-ray analysis, the following office policy prevails:

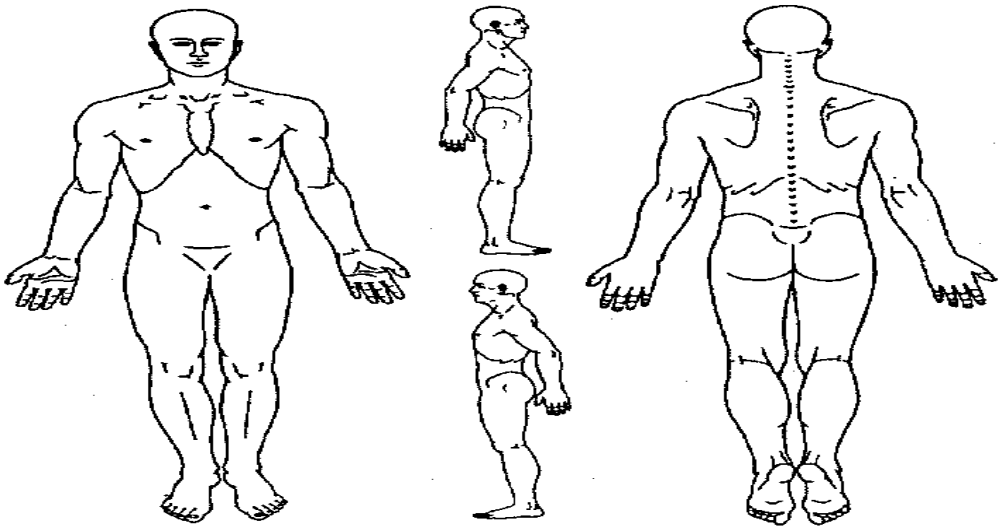
1. All first visit charges are to be paid when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

Method of payment for today's charge: ☐ Cash ☐ Check ☐ Charge

Patient's Signature: _____

Are you here for a free scoliosis check or spinal exam only? ☐ Yes ☐ No

Mark the areas on your body where you feel pain. Include all affected areas.
Describe whether the pain is Burning/Stabbing/Shooting/Dull Ache/Numbness/Pins and Needles



When and how did this first start? _____ **What makes condition better/ worse?** _____
Describe Pain: ☐ Constant ☐ Comes & Goes ☐ Better ☐ Worse ☐ Same
Has it happened before? ☐ Yes ☐ No If yes, when? _____
Does the pain radiate? ☐ Yes ☐ No If yes, where? _____
What have you done for condition in the past? _____

Health History (Check if you have ever had any of the following:)

☐ Abdominal Aortic Aneurysm	☐ Fractures	☐ Osteoporosis
☐ AIDS/HIV	☐ Glaucoma	☐ Pacemaker
☐ Alcoholism	☐ Goiter	☐ Parkinson's
☐ Allergy Shots	☐ Gonorrhea	☐ Pinched Nerve
☐ Anemia	☐ Gout	☐ Pneumonia
☐ Anorexia	☐ Heart Disease	☐ Prostate Problems
☐ Appendicitis	☐ Hepatitis	☐ Psychiatric Care
☐ Arthritis	☐ Hernia	☐ Rheumatoid Arthritis
☐ Asthma	☐ Herniated Disc	☐ Stroke
☐ Bleeding Disorders	☐ Herpes	☐ Suicide Attempt
☐ Bulimia	☐ High Cholesterol	☐ Tuberculosis
☐ Cancer	☐ Kidney Disease	☐ Tumors/Growths
☐ Cataracts	☐ Kidney Stones	☐ Typhoid Fever
☐ Chemical Dependency	☐ Liver Disease	☐ Ulcers
☐ Chicken Pox	☐ Measles	☐ UTI
☐ Diabetes	☐ Miscarriage	☐ Vaginal Infections
☐ Eczema	☐ Mononucleosis	☐ Venereal Disease
☐ Emphysema	☐ Multiple Sclerosis	☐ Whooping Cough
☐ Epilepsy	☐ Mumps	☐ Other: _____

HABITS:
Exercise ☐ Yes ☐ No If yes, explain how often and type: _____
Smoke ☐ Yes ☐ No If yes, how often? _____
Alcohol ☐ Yes ☐ No If yes, how often? _____
Caffeine ☐ Yes ☐ No If yes, how much? _____
High Stress Level ☐ Yes ☐ No If yes, reason? _____

FAMILY HISTORY: (Please list all known conditions/illnesses that apply to the following relatives)
Mother: _____ Father: _____
Grandparents: _____ Siblings: _____
Other known familial conditions: _____

Is there anything else you think we should know about or that you would like to discuss? (Explain) _____
_____