PERSONAL

NAME: _____ DATE: ____/____/____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

AGE: _____ DATE OF BIRTH: ____/____/____ MARITAL STATUS: SINGLE_____MARRIED_____ DIV_____

HOW MANY CHILDREN: _____ OCCUPATION: _____

SPOUSE: _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE#: _____

PRESENT FAMILY DOCTOR: _____ ADDRESS: _____ CITY: _____ ST/ZIP: _____

DATE OF LAST PHYSICAL: _____ BY DOCTOR: _____

LIST PRESENT COMPLAINTS

1. _____ FOR HOW LONG? _____
2. _____ FOR HOW LONG? _____
3. _____ FOR HOW LONG? _____

LIST OTHER DOCTORS CONSULTED FOR THIS COMPLAINT

NAME: _____ ADDRESS: _____

DIAGNOSIS: _____ RESULT: _____

NAME: _____ ADDRESS: _____

DIAGNOSIS: _____ RESULT: _____

SURGERY (PLEASE INCLUDE ALL TYPES)

TYPE	DATE	DOCTOR

LIST MEDICATIONS AND / OR VITAMINS

TYPE	FREQUENCY	DOCTOR

PREVIOUS ACCIDENTS & INJURIES/FRACTURES

_____

_____

MEDICATIONS / GENERAL ALLEGRIES

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST:

____SCARLET FEVER ____RHEUMATIC FEVER ____PNEUMONIA ____POLIO ____TUBERCULOSIS ____ANEMIA

____DIABETES ____HEART DISEASE ____PLEURSY ____CANCER ____ALCOHOLISM ____GOITER

____ARTHRITIS ____MENTAL DISORDER ____EPILEPSY ____VENEREAL INFECTION ____OTHER

CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST SIX (6) MONTHS:

GENERAL
____ALLERGIES
____SLEEP LOSS
____FEVER

FEMALES ONLY
____LAST PERIOD...WHEN _____
____ARE YOU PREGNANT? YES___ NO___

CVR
____CHEST PAIN
____BLOOD PRESSURE PROBLEM
____HEART PROBLEMS
____LUNG PROBLEMS/CONGESTION

MUSCULO / SKELETAL
____PAIN BETWEEN SHOULDERS
____NECK PAIN
____ARM PAIN
____JOINT PAIN / STIFFNESS
____WALKING PROBLEMS
____DIFFICULT CHEWING / CLICKING JAW
____LOW BACK PAIN

GASTRO INTESTINAL
____POOR / EXCESSIVE APPETITE
____EXCESSIVE THIRST
____FREQUENT NAUSEA
____VOMITING
____DIARRHEA
____CONSTIPATION
____LIVER TROUBLE
____GALL BLADDER PROBLEMS
____BLACK / BLOODY STOOL
____COLITIS

EENT
____VISION PROBLEMS
____HEARING DIFFICULTY

NERVOUS SYSTEM
____NUMBNESS
____PARALYSIS
____DIZZINESS
____FORGETFULNESS
____CONFUSION / DEPRESSION
____FAINTING
____CONVULSIONS
____COLD/TINGLING EXTREMITIES

MALE / FEMALE
____URINARY INFECTION
____BREAST PAIN / LUMPS
____PROSTATE / SEXUAL DISFUNCTION

HAVE YOU EVER HAD PREVIOUS CHIROPRACTIC CARE? _____ DATE OF LAST CARE _____

OUR OFFICE WILL TRY TO VERIFY YOUR INSURANCE AS A SERVICE TO YOU. YOU SHOULD ALSO VERIFY YOUR OWN INSURANCE. VERIFICATION OF INSURANCE IS NOT A GUARANTEE OF COVERAGE. ULTIMATELY YOU WILL BE RESPONSIBLE FOR YOUR HEALTH CARE.

PATIENT SIGNATURE_____ SOCIAL SECURITY NUMBER_____