(PLEASE PRINT)

Patient #_____
(office use)

PATIENT HISTORY

DATE_____

Name_____ Phone (hm)_____ (wk)_____

Cell_____ Email_____

Address, City, State & Zip_____

Birth Date_____ Age_____ ☐ Male ☐ Female Spouse's Name (or Parent/s)_____

# of Children _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed; Occupation_____

Employer_____ Work Address_____

City, State, Zip_____ Social Security #_____

How were you referred to our office?_____

Have you ever had Chiropractic Care before?_____ If yes, when?_____

List your chief complaints & Rate the Pain of your complaints on a scale from 0 to 10 (0 = no pain, 10 = Severe Pain):

1 _____ For how long?_____

2 _____ For how long?_____

3 _____ For how long?_____

List other Doctors consulted for this condition:

1 _____ Address_____

2 _____ Address_____

Is this injury or illness work-related? Yes or No Have your reported it to your employer? Yes or No
If YES, PLEASE PROVIDE THE FRONT DESK WITH THE CASE # and CASE WORKER'S NAME & PHONE # WE CAN CONTACT.

Is this injury or illness related to an auto accident? Yes or No Date of Accident: _____
Is your Claim still Open/Pending? Yes or No If YES, PLEASE PROVIDE THE FRONT DESK WITH THE AUTO INS CO'S NAME, ADJUSTER'S NAME, PHONE NUMBER AND CLAIM NUMBER. THANK YOU.

Do you have any type of Health Insurance? Yes or No If YES, PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD AND WE WILL MAKE A COPY OF IT. THANK YOU.

Are you covered under any other group or individual health policy through yourself or spouse? Yes or No
If YES, PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD AND WE WILL MAKE A COPY OF IT. THANK YOU.

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

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

Method of Payment you plan to use for today's charges: ☐ Check ☐ Cash ☐ VISA/MC/AMEX/DISC

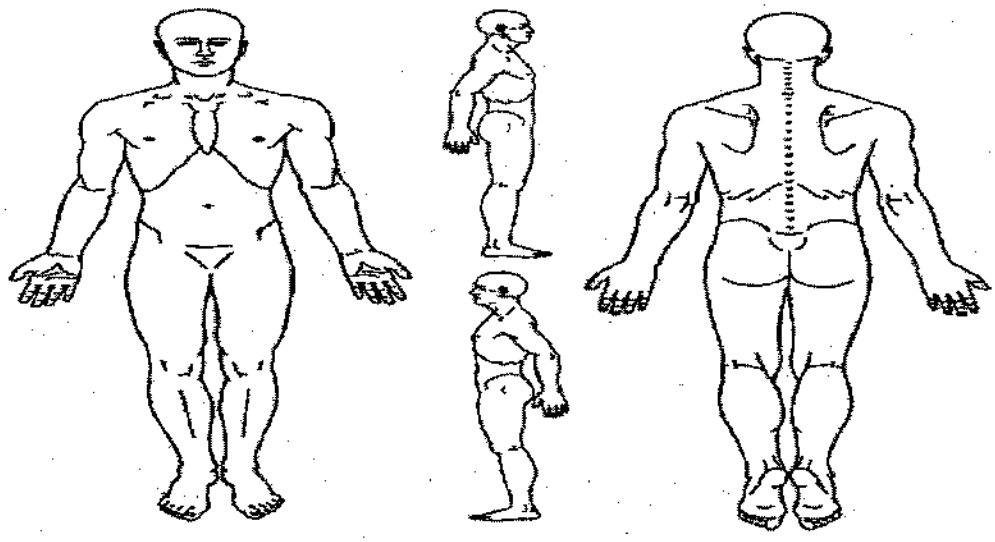
Patient's Signature/Guardian's Signature: _____

Are you here for a free consultation only? YES or NO
(does not include exams, xrays or adjustments)?

SEE OTHER SIDE FOR PAIN CHART

Mark the areas on your body where you feel pain. Include all affected areas.

Describe whether the pain is (B)Burning, (S)Stabbing, (SH)Shooting, (D)Dull Ache, (N)Numbness, (PN)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) _____

_____