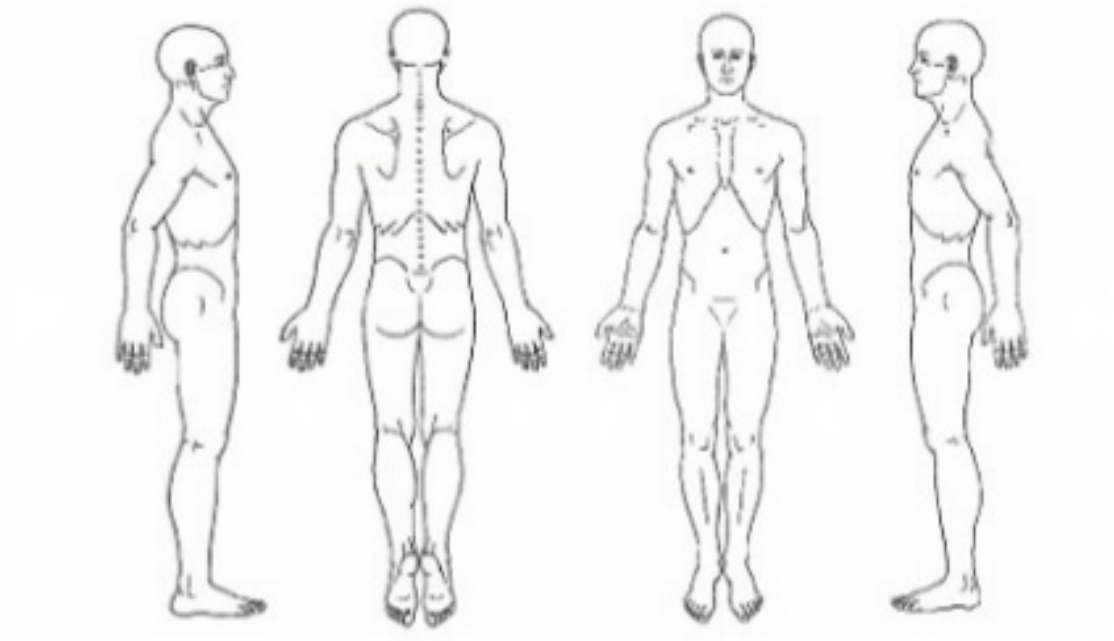
Patient Information

Full Name:	Today's Date:
Address:	City/State/Zip:
Home Phone:	Cell Phone:
Work Phone:	Email:
Preferred method of contact: Home ( ) Cell ( ) Email ( ) Text ( )	Birthdate:
Marital Status: S ( ) M ( ) W ( ) D ( )	Social Security #:
Employer:	Occupation:
Spouse's/Significant Other's Name:	Children's Names and Ages:
Emergency Contact:	Who may we thank for referring you?

Reason for Seeking Care:	Is this condition related to a recent auto or work accident? No ( ) Yes ( ) Date of Injury:
Mark on the body diagram below the areas of complaint:	Are the symptoms worse with coughing, sneezing, or bearing down? No ( ) Yes ( )



Have you ever received previous Chiropractic Care? No ( ) Yes ( )	If yes, Name of Doctor and Date of last visit:
Have you seen any other healthcare practitioners for the condition you are seeing us? No( )Yes( )	If yes, Name and type of practitioner:
List any current Prescription or Over the Counter Medications you are taking:	List any current Supplements or Vitamins you are taking:
Have you had any recent changes to your appetite? No ( ) Yes ( ) Do you have any food intolerances? No ( ) Yes ( ) How much water do you drink per day?	Do you exercise? No ( ) Yes ( ) If yes, how many hours per week? Rate your stress level over the past 90 days: (1-10 scale with 10 the highest)
How many hours do you sleep per night? Is your sleep restful? No ( ) Yes ( )	Does your condition interrupt your sleep? No ( ) Yes ( ) Do you wake during the night due to your complaint? No ( ) Yes ( )
Briefly describe what you spend most of your time doing:	Are you currently able to fully engage in those activities without pain or stress? No ( ) Yes ( )

Have you ever had any Surgeries? No ( ) Yes ( ) If yes, please explain:
Have you ever been Hospitalized? No ( ) Yes ( ) If yes, please explain:
Have you ever been diagnosed with Cancer or Diabetes? No ( ) Yes ( ) If yes, please explain:
Are you HIV positive? No ( ) Yes ( ) If yes, date of diagnosis:
Do you have any Family History of Heart Disease, Cancer, Stroke, or Back Problems? No ( ) Yes ( )
Which best describes your goal to achieve through chiropractic care? Relief from your current symptoms ( ) Correction of the underlying cause of your symptoms ( ) Maintaining optimal health ( )
Do you have any other health concerns you would like to discuss with the doctor today? No ( ) Yes ( ) If yes, please explain:

Signature_____ Date_____

Health History Review

Please check any symptoms or conditions that apply to you
or that have occurred in the past 6 months:

Injuries/Trauma: please list date

( ) Back Injury	( ) Fall	( ) Soft Tissue Injury
( ) Fracture/Broken bone	( ) Head Trauma	( ) Disability
( ) Motor Vehicle Injury	( ) Joint Injury	( ) Other

General History:

( ) Anemia	( ) Fatigue/Weakness	( ) Night Sweats
( ) Excessive Bleeding/Bruising	( ) Recent Weight Loss/Gain	( ) Psychological Illness

Gastrointestinal/Stomach/Digestion:

( ) Abdominal pain/Swelling	( ) Hepatitis/Jaundice	( ) Rectal bleeding
( ) Heartburn/Reflux/Ulcer	( ) Constipation/Diarrhea	( ) Hemorrhoids
( ) Gallbladder illness	( ) IBS/Crohn's Disease	( ) Diverticulitis/Appendicitis

Respiratory/Lung:

( ) Shortness of breath	( ) Pneumonia	( ) Prolonged cough
( ) Asthma/Weezing	( ) Tuberculosis	( ) Other

Eyes/Ears/Nose/Throat:

( ) Eye/Visual problems	( ) Hearing loss	( ) Nosebleeds
( ) Allergies/Sinusitis	( ) Tinnitus/Ringing in ears	( ) Frequent sore throat
( ) Ear pain or discharge	( ) Dizziness/Vertigo	( ) Swollen/Painful glands
( ) Frequent ear infections	( ) Altered sense of smell/taste	( ) TMJD/Dental conditions

Endocrine/Hormonal:

( ) Diabetes	( ) Cold/Heat intolerance	( ) Excess hunger/thirst
( ) Thyroid condition	( ) Unusual hair loss/growth	( ) Hormone therapy

Nervous System:

( ) Dizziness/Syncope/Fainting	( ) Numbness	( ) Slurred speech
( ) Loss of consciousness	( ) Seizures/Tremors	( ) Unsteadiness of gait

Cardiovascular/Heart:

( ) Heart Disease/Surgery	( ) High Cholesterol	( ) Palpitations
( ) Blood Pressure High/Low	( ) Swelling of ankles/feet	( ) Heart murmur

Urinary System:

( ) Frequent/Painful urination	( ) Kidney Disease	( ) Pelvic/Flank pain
( ) Chronic bladder infections	( ) Blood in urine	( ) Difficulty initiating urination

Musculoskeletal:

( ) Muscle spasm/tightness	( ) Joint Pain/Swelling	( ) Osteoarthritis
( ) Strain/Sprain	( ) Muscle weakness	( ) Rheumatoid arthritis
( ) Osteoporosis	( ) Postural abnormalities	( ) Psoriatic arthritis

Skin:

( ) Rash	( ) Scarring	( ) Bruising
( ) Psoriasis	( ) Eczema	( ) Inflammation

Female History:

( ) Abnormal bleeding/discharge	( ) Birth control pills/IUD/Depo-provera/Etc.
( ) Irregular menstruation	( ) Hysterectomy
( ) Cramps/pelvic pain	( ) Fibroids/Ovarian cyst
( ) Breast lump/pain	( ) Heavy menstrual bleeding
( ) Pregnancy	Are you currently pregnant? ( ) No ( ) Yes

Male History:

( ) BPH/Prostate Disease	( ) Urinary retention
( ) Erectile dysfunction	( ) Hesitancy/dribbling

Family History:

( ) Backache	( ) Cancer
( ) Arthritis	( ) Alzheimer's
( ) Diabetes	( ) Dementia
( ) Heart Disease	( ) Parkinson's
( ) Stroke	( ) Tremors

Medical History:

Primary Care Physician :	Date of last visit:
Date of last physical exam:	Date of last blood work/labs:
Date of last X-ray taken:	Date of last MRI/CT:

Signature:_____Date:_____