



WELCOME

PATIENT INFORMATION

Date _____

Name _____

Last Name

First Name

Sex M F Age _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Employer _____ Phone (_____) _____

E-mail _____

Marital Status Married Single Divorced Separated

Spouse's Name _____

Child(ren) Name(s)/Age(s) _____

Who may we thank for referring you? _____

PATIENT CONDITION

Reason for Visit _____

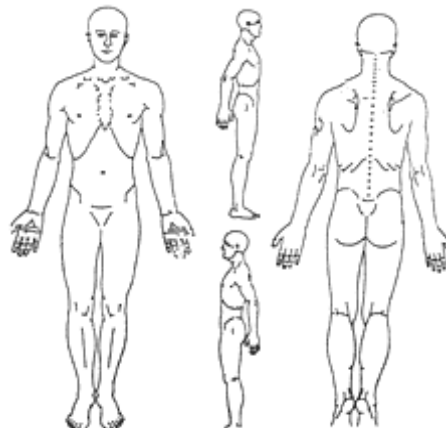
When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Type of pain: Sharp Dull Throbbing Numbness Aching
 Burning Tingling Cramps Stiffness Swelling

Rate the severity of your symptom on a scale from 1 (least) to 10 (most severe) _____

Mark and X on the picture where you are experiencing symptoms.



HEALTH HISTORY

What treatment have you already received for your condition? Chiropractic
 Physical Therapy Medication Surgery None

Name of other doctor(s) seen _____

Please mark to indicate if you have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Other _____ | | | |

EXERCISE None Moderate Daily Heavy

WORK ACTIVITY Sitting Standing Light Labor Heavy Labor

HABITS Smoking Alcohol Coffee/Caffeine High Stress Level

Injuries/Surgeries _____

Medications _____
