Name_____ Date_____

Address_____ State_____ Zip_____

Home phone_____ Cell Phone_____ Work Phone_____

Email address _____ Sex M/F Age _____

DOB _____ SS# _____ Marital Status/ S M D W

Occupation _____ Employer _____

Work Address _____

If applicable:

Parents/Legal Guardians Name _____

Address_____

Home phone _____ Work Phone _____

No. of Children _____

How did you hear about our office? _____

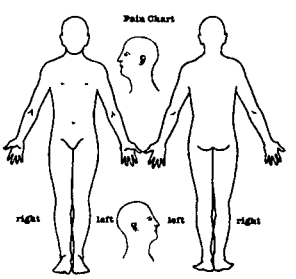
Main Complaint

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
   _____
3. What is your treatment goal? _____
4. If this is a recurrence, when was the first time you noticed the problem? _____
5. How did it originally occur?_____
6. Has it become worse recently? Yes_____ No_____ Same_____ Gradually Worse_____
   If yes, when and how? _____
7. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only _____
8. How long does it last? All Day_____ Few Hours _____ Minutes _____
9. How many days have you lost wok due to these symptoms? _____
10. Are there any other conditions or symptoms that may be related to your major symptoms Yes _____ No _____. If yes, describe_____
    _____
11. Are there other unrelated health problems? Yes_____ No_____ If yes, describe_____
    Describe the pain: Sharp_____ Dull_____ Numbness_____ Tingling_____ Aching_____ Burning _____ Stabbing _____
    Other _____
12. Is there any thing you can do the relieve the problem? Yes_____ No_____. If yes, describe_____
    _____. If no, what have you tried to do that has not helped?_____
    _____
13. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending_____ Lifting_____ Twisting_____ Other_____
    _____
14. Have you had any broken bones? Yes_____ No_____. If yes, please list and give dates_____
    _____
15. List any major accidents you have had other than those that might be mentioned above: _____
    _____
16. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? _____
    _____
17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes____ No____ Uncertain ____
    Remarks: _____
    _____
    _____

No Pain Unbearable Pain

Please place an "X" on the line above to indicate level of problem.

Show area(s) of pain or unusual feeling, pain or discomfort.



Past History

Past Chiropractic care / doctor's name_____

Family physician _____ Medications_____

Surgeries / dates_____

Illness / abnormalities _____

Previous Injuries & accidents / dates_____

Do you have difficulty with any of the following?

- ❑ Headaches
- ❑ Shooting head pains
- ❑ Sinus Trouble
- ❑ Loss of smell
- ❑ Hayfever
- ❑ Asthma/allergies
- ❑ Loss of taste
- ❑ Tightness in throat
- ❑ Inflammation of throat
- ❑ Thyroid Trouble
- ❑ Face flushed
- ❑ Twitching of face
- ❑ Loss of memory
- ❑ Fatigue
- ❑ Depression
- ❑ Head feels too heavy
- ❑ Weight gain
- ❑ Fainting
- ❑ Loss of balance
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Light bothers eye
- ❑ Muscle spasms in neck
- ❑ Grating in neck
- ❑ Tightness of shoulder muscle
- ❑ Neuritis in shoulders & arms
- ❑ Pins & needles in hands
- ❑ Cold hands
- ❑ Chest pains
- ❑ Shortness of breath
- ❑ Heart attacks
- ❑ Heart pain
- ❑ Heart palpation
- ❑ Weight loss
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Anemia
- ❑ Rheumatic Fever
- ❑ Nervous stomach
- ❑ Stomach trouble
- ❑ Ulcers
- ❑ Nerves & nervousness
- ❑ Inner tension
- ❑ Irritability
- ❑ Cold sweats
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Indigestion
- ❑ Intestinal gas
- ❑ Constipation
- ❑ Bladder Trouble
- ❑ Menstrual cramps & pain
- ❑ Menstrual Irregularity
- ❑ Diabetes
- ❑ Cancer
- ❑ Sleeping problems
- ❑ Painful joints
- ❑ Swollen joints
- ❑ Arthritis
- ❑ Slipped disk
- ❑ Pinched nerves in back
- ❑ Pins & needles in legs
- ❑ Swollen ankles
- ❑ Cold feet
- ❑ Pains in legs & feet
- ❑ Kidney trouble

Family Medical History

Breast cancer	Other cancers	Cardiovascular disease	Stroke
Osteoporosis	Alcoholism	Mental illness/Depression	Obesity
Alzheimer's	Diabetes	Arthritis	Allergies

Please place an "F" for father or father's side or "M" for mother's side of the family in front of anything you circled in this section above.

Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are the major causes? Work Family Finances Relationships Emotions

Other _____

I eat the following:

Sweets	Sodas/Pop	Ice cream	Fried foods
Cereals	Legumes	Fruits	Vegetables

List your 4 favorite foods: _____

This applies to me: Diet frequently Skip meals Dine out regularly

Eat (0 1 2 3 4 5 6 more) meals a day

When do you eat? Morning, Noon, Night, Constantly snacking

Do you:

-use tobacco? YES or NO If yes, how much daily? _____

If no, did you ever? YES or NO if yes how long? _____

-Are you exposed to second hand smoke YES or NO If yes, how much daily? _____

If no, did you ever? YES or NO if yes how much? _____

-drink coffee? YES or NO If yes, how much daily? _____

If no, did you ever? YES or NO if yes how much? _____

Is it - strong mild decaf?

-eat chocolate? YES or NO If yes, how much daily? _____

-drink alcohol? YES or NO If yes, how many ounces a day/ week? _____

If no, did you ever? YES or NO if yes how much? _____

How long did you drink before you stopped? _____

-restrict your intake or avoid completely:

Fiber	Salt	Sugar	Fat
Dairy products	Animals protein	All animal foods	

Exercise

Exercise weekly? YES or NO If yes, how many times per week? _____