WELCOME TO OUR OFFICE

PATIENT:

Last Name:	Firs	t Name:	Middle:	
Gender: M F Date of Birth://				
Home Address:				
City:				
Home Phone #:	Work F	Phone #:	Cell #:	
Employer Name:		Occupation:		
Employer Address:			Apt #:	
City:		State:	Zip:	
SPOUSE or GUARDIAN:				
Last Name:	Firs	t Name:	Middle:	
Employer Name:		Work Phone #:		
Date of Birth://		SS#:		
EMERGENCY Name and address of neare	est relative	e or friend not living w	vith you:	
Last Name:	Firs	t Name:	Middle:	
Home Phone #:		Work Phone #:		
Relation to Patient:				
Primary Care Physician:				
Phone #:				
What is the main health problem you want t	o talk to t	he doctor about?		
How long have you had this condition?				
What activities aggravate your condition?				
Is this condition getting worse? ☐ Yes ☐ No ☐ Co	mes and go	oes 🛘 Constant Number	of episodes per day per week	per mo
Condition interfering with your up work up s	leep 🖵 da	aily routine 🛭 other _		
Drugs you now take: ☐ Nerve pills ☐ Pain killers	☐ Muscle i	relaxers 🗅 "Pep" pills 🗅 T	ranquilizers 🛘 Birth control pills 🖵	None Other
MEDICATION DOSAG	3E	REASON	DC	CTOR
		DESCRIBE BRIEFLY		
Been knocked unconscious?				
Used a cane, crutch, or other support?				
Been treated for a spine or nerve disorder?	0 0.			
Had any fractures or dislocations?	0 0.			
Had any accidents or falls?	0 0.			
Been hospitalized for other than surgery?				
Have you ever been in an auto accident?	0 0			

HEALTH REPORT

General		Gastro-intesti	nal	Cardio-va	scular
☐ Allergies		☐ Colon Trouble		☐ Stroke	maiding to neite past
☐ Dizziness		Constipation		☐ High blood	d pressure
☐ Headache		☐ Liver Trouble		☐ Low blood	pressure
☐ Fainting		☐ Gall bladder pro	blems	☐ Poor circu	lation
□ Numbness		Vomiting of block	Pain Pills Cottee bo	☐ Rapid hea	rt rate
☐ Excessive weig	ht loss	Poor appetite		☐ Slow hear	t rate
☐ Frequent loss of	f sleep	□ Nausea		☐ Swelling o	f ankles
Muscle and Jo	oint	Eyes, Ears, No	se, Throat	Skin	
☐ Arthritis		Asthma		☐ Bruise eas	sily
☐ Bursitis		Frequent Colds		☐ Itching	
Swollen joints		Deafness		Dryness	
Poor posture		☐ Earache			
☐ Spinal curvatur	е	Ear noises		For Wome	en Only
		☐ Eye pain		☐ Cramps o	r backache
		☐ Failing vision		□ Excessive	menstrual flow
Genito-Urinar	y	☐ Frequent noseb	leeds	Hot flashe	S
□ Bed wetting		Sinus infections	Pain Pilis Other	Irregular o	ycle
☐ Blood in urine		Enlarged glands	3	☐ Painful me	enstruation
☐ Frequent urinat	ion	☐ Hay fever		Are you preg	gnant? 🗆 Yes 🕒 No
☐ Painful urination	n				
☐ Prostate trouble	9				
☐ Kidney trouble					
Check the following	ng conditions you hav	re had:			
☐ Alcoholism		☐ Cancer Type:_	1. HARE SELECT OF THE REAL PROPERTY.	☐ Diabetes	
☐ Arteriosclerosis		☐ Emphysema		☐ Epilepsy	
□ Gout		☐ Heart disease		☐ Multiple so	clerosis
☐ Rheumatic feve	r	□ Stroke		☐ HIV/AIDS	
HABITS:	Alcohol	☐ Heavy	☐ Moderate	□ Light	☐ None
	Caffeine	0			
	Tobacco				
	Exercise			(edited	
Do you wear?	Custom orthotics	☐ Heel lifts ☐ Ar	ch supports		
Do you:					
Now take vitamins	s or minerals?	☐ Yes ☐ No			
Think you may ne	ed vitamins/minerals	? ☐ Yes ☐ No			
Have an allergy to	drug or food?	☐ Yes ☐ No	Type		<u>137</u>) n
Does any member	r of your family have:	(please circle)			
arthritis heart di	sease cancer dia	betes epilepsy lu	ng disease emotional ¡	problems intestir	al disorders
scoliosis spinal	arthritis neck or bac	ck pains abnormal	spinal development		
other health probl	ems? Yes / No Wh	nom? Father Mot	her Sister Brother	Aunt Uncle	
I CERTIFY THAT	ALL INFORMATION G	IVEN IS TRUE AND O	CORRECT Lhereby author	rize the release of	any information requ

I CERTIFY THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all services rendered. I agree that if my treatment here is suspended or terminated, fees become immediately due and payable. All X-rays are the property of this Chiropractic Center.

FOR OFFICE USE ONLY, DO NOT WRITE IN THIS SPACE

PRIMARY COMPLAINT

Exact description of problem

1500	Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness	Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to Severity 1 2 3 4 5 6 7 8 9 10		100000		Date	Same Better Worse than	Date	THE WAR	Date	
	Crawling	5 6	Other				Better				
	urning	2 3 4	Heat				Same				
	asm B	erity 1	Cold								
Constitution	Cramp Sp	Seve	Movement	J. Southfillow			Date		10 10 10 10 10 10 10 10 10 10 10 10 10 1	BITTITIZA, I	
	g Pulling	Radiating to	Inactivity	boold to	Colonia Colonia				e wose		
	ng Stabbing	ntermittent	Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other	Other					110000		
	ie Throbbir	Constant	Vorse with:	Pain Pills					Other		tions)
	urt Ach	ROM .	>	Heat					ork C		complica
THE D	ate): Hi	Loss of	Night	Cold	Cloud		MEDING	(e)	me W	Selung	roblem (
end bao	appropri	Stiffness	Evening	Rest	The state of the s			nt (describ	rat Ho	SIBERIN	assoc. with problem (complications)
Salate Carlo	of pain (circle	Numbness	Morning	Exercise	a of pain	& when)	ee	Related to fall or accident (describe)	Did fall or accident occur at Home Work Other	Was Pt in Auto Accident	
	Character c	Prickling	Worse in:	Better with:	Related area of pain_	Onset (how & when)	Reoccurrence	Related to fa	Did fall or a	Was Pt in A	Other circumstances

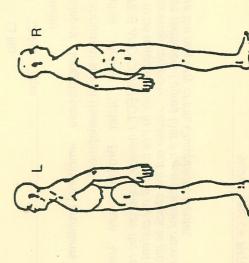
before

SECONDARY COMPLAINT

Exact description of problem

a character as a contract of the contract of t	9_	Worse in: Morning Evening Night Worse with: Exercise Inactivity Movement Cold Heat Other Better with: Exercise Rest Cold Heat Pain Pills Other	Related area of pain	Onset (how & when)	Reoccurrence Same Better Worse th	Related to fall or accident (describe)	Work Other	Was Pt in Auto Accident Date	Other circumstances assoc. with problem (complications)		Exact description of problem		Character of pain (circle appropriate): Hurt Ache Throbbing Stabbing Pulling Cramp Spasm Burning Crawling Soreness	Prickling Numbness Stiffness Loss of ROM Constant Intermittent Radiating to Severity 1 2 3 4 5 6 7 8 9 1	Moreo in: Morning Evening Night Moreo with: Evening Incetivity, Mayonant Oald Doct Other	
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nan before



Patient	Denies	Pregnand
ationit	Domoo	rograme

Date:

Worse than before

Better

Same

Date

Date

Date

Other circumstances assoc. with problem (complications)

Other

Work

Home

Related to fall or accident (describe)

Did fall or accident occur at Was Pt in Auto Accident

Date

9 10

Other

Pain Pills

Heat

Cold

Exercise

Better with:

Related area of pain Onset (how & when) Reoccurrence

cy Signature:



