The BACK DOCTORS
experience gonstead chiropractic

PATIENT INFORMATION **CONFIDENTIAL**

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name____ Date_____/_____/_____ S/S______-______-______

First MI Last

Address____ City________________ State_____ Zip__________

Home Phone_______________________ Work Phone_______________________ Cell Phone____________________

Birth Date_____/_____/_____ Age_____ Height________ Weight________ e-mail address:________________________

Who may we thank for referring you to us? ____

SO WE CAN GET TO KNOW YOU BETTER

Your Employer____ Occupation_________________________________

Spouse/ Parent's Name____ Phone_________________

Do you have children? ❒ Yes ❒ No

Name(s) & Age____

Person to contact in case of an emergency____ Phone_________________

HEALTH HISTORY

Do you currently have or have you previously had any of the following symptoms:

- ❒ Headaches
- ❒ Neck Pain
- ❒ Neck Stiffness
- ❒ Mid Back Pain
- ❒ Low Back Pain
- ❒ Arm Pain
- ❒ Leg Pain
- ❒ Pins and Needles in Arms
- ❒ Pins and Needles in Legs
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Cold Hands
- ❒ Cold Feet
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Mood Swings
- ❒ Sleeping Problems
- ❒ Fatigue
- ❒ Depression
- ❒ Chest Pain
- ❒ Shortness of Breath
- ❒ Cold Sweats
- ❒ Fever
- ❒ Fainting
- ❒ Dizziness
- ❒ Loss of Balance
- ❒ Light Sensitivity with Eyes
- ❒ Ringing/ Buzzing in Ears
- ❒ Loss of Memory
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Upset Stomach
- ❒ Constipation
- ❒ Diarrhea
- ❒ Urinary Problems
- ❒ Heartburn
- ❒ Ulcers
- ❒ Allergies
- ❒ Menstrual Pain
- ❒ Menstrual Irregularity
- ❒ Hot flashes

Because accumulation of stress affects our health and ability to heal we are interested in knowing your current stress level?

❒ Low ❒ Medium ❒ High

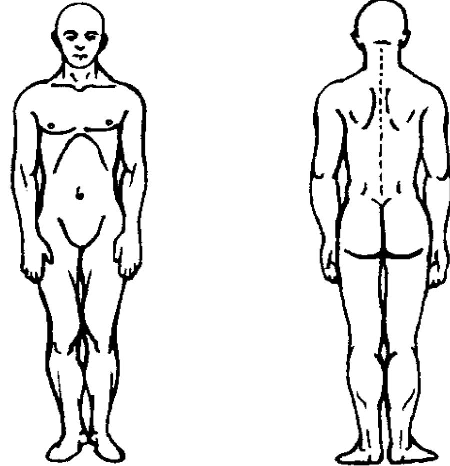
Please list your top stresses in each category.

❒ Physical (falls, accidents, work posture, etc.) ____

❒ Emotional (work, relationships, finances, etc.) ____

❒ Chemical (smoke, unhealthy foods, drugs/alcohol, etc.) ______________________________________

PLEASE MARK YOUR CURRENT AREAS OF COMPLAINT:



Current Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Does anything relieve your pain? ______________________________

Please describe any activities that are restricted due to this injury?

____

____

Have you ever been diagnosed with a Subluxation? ❒ No ❒ Yes, When? ______________________________

Have you been adjusted by a Chiropractic before? ☐ Yes ☐ No

Have you had x-rays before? ❒ No ❒ Yes, When? ______________ What areas? ______________

I am currently taking the following medications for the following reasons: ❒ None

____

Surgical History: ______________________________ ❒ None

Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

Which best describes your health goals: ❒pain relief only ❒correct entire problem ❒ wellness/ preventative care

Again, thank you for choosing us for your health care needs!

DATE: ______/______/______ SIGNATURE: ______________________________

PARENT/ GUARDIAN:______________________________