

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_ 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 \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 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:

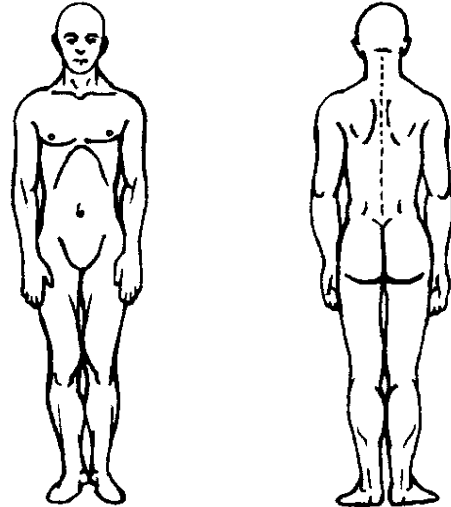
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Tension                     | <input type="checkbox"/> Ringing/ Buzzing in Ears |
| <input type="checkbox"/> Neck Pain                | <input type="checkbox"/> Irritability                | <input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

What is your current stress level?

- Low       Medium       High

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**PLEASE MARK YOUR CURRENT AREAS OF COMPLAINT:**



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How often do you notice your symptoms?  Constantly  Frequently  Occasionally

Does anything relieve your pain? \_\_\_\_\_

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

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When did you first notice these symptoms? \_\_\_\_\_

Have you had this problem before?  No  Yes, When? \_\_\_\_\_

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

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Surgical History: \_\_\_\_\_  None

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

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

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Who should receive bills for payment on your account?

- Patient  Spouse  Parent  Worker's Comp  
 Medicare  Medicaid  Personal Health Insurance

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

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE: \_\_\_\_\_

PARENT/ GUARDIAN: \_\_\_\_\_