



Date _____ Birthday _____ Sex: Male Female

First Name _____ Middle Initial _____ Last Name _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Email: _____

Married/Civil Union: Single Married Divorced Widowed Other

How did you find out about our office?: _____

Emergency Contact Full Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Employment Information:

Employment: Full Time Employed Part Time Employed Full Time Student

Part Time Student Retired Unemployed

Employer Name: _____ Occupation: _____

Employer Address: _____

Purpose of Visit: Wellness Complaint Injury Other

Where did the injury occur?: _____ Date of Injury (if known): _____

Describe how the injury, pain, or discomfort originated: _____

Rate 1-10 (10 being the worst): _____ Describe your pain/discomfort: _____

Current Symptoms: _____

Select frequency you experience pain from this condition: Always Hourly Daily Occasionally

Does this condition interfere with any of your daily activities or routines? Yes No

Has this condition affected your appetite? Yes No

Have you missed any work due to this injury? Yes No

Have you reduced/limited your work hours due to this condition? Yes No

Is the pain/discomfort worse at certain times of the day? Yes No

Does the weather affect your pain/discomfort? Yes No

List anything that aggravates your condition: _____

Have you received professional treatment for this condition? Yes No

Have you had X-rays taken for this condition? Yes No

Have you ever had this same condition? Yes No

List other practitioners seen for this injury/condition: _____

Has this condition affected your quality of sleep? Yes No If yes, explain: _____

If yes, what dates have you missed work because of this? _____

List anything that relieves or improves your condition: _____

Please select all that you have had or currently have:

- Allergies Alcoholism Anemia Arteriosclerosis Arthritis Asthma Back Pain
- Breast Lump Bronchitis Bruise Easily Cancer Chest Pain Cold Extremities Constipation
- Cramps Depression Diabetes Digestion Problems Dizziness Excessive Menstruation
- Eye Pain or Difficulties Fatigue Frequent Urination Headache Hemorrhoids
- High Blood Pressure Hot Flashes Irregular Heart Beat Irregular Menstrual Cycle
- Kidney Infection Kidney Stones Loss of Memory Loss of Balance Loss of Smell

- Loss of Taste Nosebleeds Pacemaker Polio Poor Posture Prostate Trouble Sciatica
- Shortness of Breath Sinus Infection Sleep Problems/Insomnia Spinal Curvature Stroke
- Swelling of Ankles Swollen Joints Thyroid Condition Tuberculosis Ulcers
- Varicose Veins Venereal Disease Other _____

Social History and Life Choices:

Alcohol: Daily Weekly Occasionally Never

Water: Daily Weekly Occasionally Never

Tobacco: Daily Weekly Occasionally Never

Exercise: Daily Weekly Occasionally Never

Soft Drinks: Daily Weekly Occasionally Never

Caffeine Drinks/Products: Daily Weekly Occasionally Never

Diet Food Products: Daily Weekly Occasionally Never

Medications: Daily Weekly Occasionally Never

Energy Products/ Over-the-Counter Stimulants: Daily Weekly Occasionally Never

Fresh & Homemade Foods: Daily Weekly Occasionally Never

Preprocessed, Packaged, & Restaurant Food: Daily Weekly Occasionally Never

For Women Only:

Are you pregnant? Yes No Are you nursing? Yes No Are you taking birth control? Yes No

Do you experience painful periods? Yes No Do you have irregular cycles? Yes No

Do you have breast implants? Yes No

Personal Incident History:

Broken bones? Yes No If yes, briefly explain: _____

Been hospitalized? Yes No If yes, briefly explain: _____

Past Surgeries? Yes No If yes, briefly explain: _____

Stroke? Yes No If yes, briefly explain: _____

Struck unconscious? Yes No If yes, briefly explain: _____

Major sprains/strains? Yes No If yes, briefly explain: _____

Please list diagnosed health conditions and untimely death (condition, relationship to you).
(Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles)

(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

Goals for Your Care:

Please list what you would like to be able to do after treatment that you cannot currently do because of your condition:

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

I agree with this statement of authorization

Signature _____ Date _____