Date _____ Email _____

Personal Information

Full Name _____Age _____ Date of Birth _____
Address _____ City _____ State_____ Zip_____
Phone (Home) _____ Marital Status: S M D W Social Security # _____
Occupation/Employer _____ Phone (Work)_____
Spouse's Name _____Spouse's Occupation _____
Spouse's Employer _____Spouse's Phone (Work)_____
In Case of Emergency Notify: _____ Phone: _____

I will be paying for my services and should be considered eligible for the Time of Service discount Y/ N
I might have insurance that covers chiropractic care Y/ N/ Unsure
Insurance Company_____
Insured's Name _____ Relationship to Insured _____
Insured's Date of Birth _____ Insured's ID. # _____

Who may we thank for referring you? (Their Name) _____
Phone Book Newspaper Sign Staff Website Dr. _____ Other: _____

What are your main complaints? 1._____ 2. _____ 3. _____
What activities aggravate your complaint?_____
What activities lessen your complaint?_____
Is this condition worse during certain times of the day? Y/N Explain: _____
Is this condition interfering with: Work?_____ Sleep?_____ Daily Routines? _____Other? _____
Is this condition progressively getting worse? _____Since When?_____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Stroke	O Loss of Memory	O Fever
O Pain in Hands/ Arms	O Nervousness	O Diarrhea	O Asthma
O Chest Pains	O Fatigue	O Mid Back Pain	O Weight Loss
O Neck Pain	O Cancer	O Shoulder Pain	O Loss of Balance
O Numb Hands/ Arms	O Tension	O Constipation	O Allergies
O Heart Attack	O Depression	O Neck Stiff	O Loss of Smell/ Taste
O Sleeping Problems	O Painful Urination	O Sinus	O Ringing in Ears
O Pain in Legs or Feet	O Irritability	O Stomach Upset	O Cold Hands/ Feet
O High Blood Pressure	O Lights Bother Eyes	O Joint Swelling	O Menstrual Cramps
O Low Back Pain	O Diabetes	O Shortness of Breath	O Jaw/TMJ Problems
O Numb Legs/ Feet	O Dizziness	O Heartburn/Reflux	O Menopause

Social History

Do you smoke Y/N, How Much/How Often _____Alcohol Y/N Daily/ Weekly/ Social
Caffeinated drinks per day ____ Do you take Vitamins/Supplements Y/N
Type and how often _____ Have you had surgery?_____
Females Only Last Menstrual Period began on_____ Are you possibly Pregnant? Y/ N
Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____