Phone Number:

Patient Information

Date:		SSN:		Birthday:	
First Name:		Middle Name:		Last Name:	
Sex:	◯M ◯F	Height:		Weight:	
Marital Status:	◯Yes ◯No	Spouse Name:		# of Children:	
Home #:		Cell #:		Work #:	
Address:					
City:		State:		Zip:	
Emergency Contact:		Emergency Relation:		Emergency Phone:	
Email:					

Referral Information

Referring Physician:		Referred Patient:		Referred by:	
Advertisement:	◯Yes ◯No	Advertisement:			
Referred Directory:	◯Yes ◯No	Referred Directory:			

History

Last Physical Exam:		Primary Phys:		Phys Phone #:	
Phys City:		Phys State:		Phys Zip:	
Health Conditions:					
Previous Chiro Care:	◯Yes ◯No	Date:		Explain:	
Chance Pregnant:	◯Yes ◯No	Planning:	◯Yes ◯No		
Medications:					
Supplements:					
Broken Bones:	◯Yes ◯No	Treatment:	◯Yes ◯No	Explain:	
Sprains/Strains:	◯Yes ◯No	Treatment:	◯Yes ◯No	Explain:	
Hospitalized:	◯Yes ◯No	Explain:			
Surgery:	◯Yes ◯No	Explain:			
Auto Accident:	◯Yes ◯No	Treatment:	◯Yes ◯No	Explain:	
Struck Unconscious:	◯Yes ◯No	Treatment:	◯Yes ◯No	Explain:	
Eating Disorder:	◯Yes ◯No	Explain:			
Stroke:	◯Yes ◯No	Explain:			
Family Health Hist:					

Complaint Information

Injury Occurred: ◯ Automobile ◯ Work ◯ Third-Party ◯ Other Injury Date: ____________

Injury Origin: ____________

Desc Discomfort: ____________

Frequency: ◯ Always ◯ Hourly ◯ Daily ◯ Occasionally

Interfere w/ Activities: ◯ Yes ◯ No Affected Sleep: ◯ Yes ◯ No

Missed Work: ◯ Yes ◯ No Unable to Work from: ____________ Unable to Work til: ____________

Affected Appetite: ◯ Yes ◯ No Explain: ____________

Reduced Work: ◯ Yes ◯ No Explain: ____________

Does it Worsen: ◯ Yes ◯ No Explain: ____________

Weather Affects it: ◯ Yes ◯ No Explain: ____________

Aggravates Condition: ____________

Improves Condition: ____________

Received Treatment: ◯ Yes ◯ No Explain: ____________

X-rays Taken: ◯ Yes ◯ No Explain: ____________

Same Condition Before: ◯ Yes ◯ No Date: ____________ Practitioner: ____________

Health Checklist

- [ ] 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
- [ ] High Blood Pressure
- [ ] Sinus Infection
- [ ] Insomnia
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other: ____________

Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Processed Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Tobacco:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never					

Employer Information

Employed: ◯ Full Time ◯ Part Time ◯ Homemaker ◯ Unemployed Employer Name: ____________________

Employer Address: ____________________

Employer City: ____________ Employer State: ____________ Employer Zip: ____________

Occupation: ____________ Work Supervisor: ____________ Supervisor #: ____________

Work Duties: ____________________

Patient Signature: ____________________ Date: ____________