

NAME: (first) _____ (initial) _____ (last) _____ **DATE:** _____
DATE OF BIRTH: _____ **Home phone:** _____ **Day phone:** _____ **Cell:** _____
Address: _____
Email: _____ (Used for appointment reminders)
City: _____ **State:** _____ **Zip:** _____ **Marital status:** _____ **S.S. number:** _____
Number of Children: _____ **Spouse's name (parents' names if minor):** _____
Occupation (if retired, former occupation): _____ **Employer:** _____
Nearest relative: _____ **Phone:** _____
How did you find out about our office? _____
Family medical physician: _____ **City:** _____ **Date of last exam:** _____
Would you like initial and progress reports sent to your family physician? _____

Reasons for your visit to our office:

- 1) _____ How long have you had symptoms? _____
- 2) _____ How long have you had symptoms? _____
- 3) _____ How long have you had symptoms? _____

Remarks: _____

Check if accident related: ___Auto ___Work ___Home ___Athletics ___Other: _____

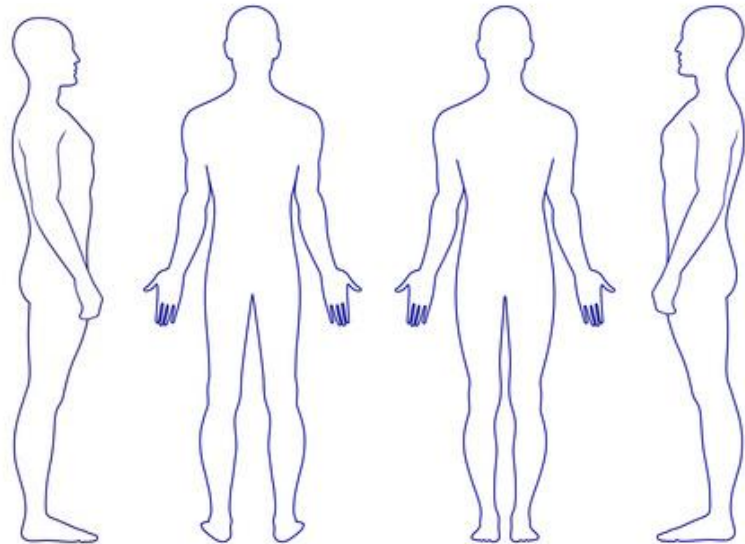
--Have you see a chiropractor before? ___yes ___no

Other health care providers seen for above complaints:

Name: _____ Dates: _____ Diagnosis: _____
 Treatment: _____ Result: _____
 Name: _____ Dates: _____ Diagnosis: _____
 Treatment: _____ Result: _____
 Name: _____ Dates: _____ Diagnosis: _____
 Treatment: _____ Result: _____

Pain drawings- mark your pain areas on the diagrams as indicated:

- Xxxx = pain
- /////// = tingling/needles
- ooooo = burning
- +++++ = numbness
- www = weak



Surgeries: (please list all)

Date: _____
 Date: _____
 Date: _____
 Date: _____

Medications:

1 _____/reason: _____ 2 _____/reason: _____
 3 _____/reason: _____ 4 _____/reason: _____
 5 _____/reason: _____ 6 _____/reason: _____

List serious accidents/falls with dates: _____

Check the following conditions you have or had:

- scarlet fever rheumatic fever polio tuberculosis whooping cough anemia
 measles mumps chicken pox diabetes heart attack cancer: _____
 pleurisy alcoholism chronic infection: _____

Carbonated drinks: occasional/none frequent **Smoke?** _____ packs per day **Alcohol:** _____drinks per (day)(week)(month)
 Recreational drug use? What? _____ Frequency? _____

REVIEW OF SYSTEMS: **CIRCLE** current problems, put a **✓CHECK** next to former problems

- | | | | |
|------------------------------|------------------------|----------------------------|-------------------------------|
| Neck stiffness or pain | fever | poor or excessive appetite | chronic cough |
| Arm/wrist/hand pain | chills | burping or gas | cough with mucous or phlegm |
| Headache | sweats | nausea | chest pain |
| Low back pain | fainting | vomiting | difficult breathing |
| Other back pain | dizziness | abdominal pain | asthma or emphysema |
| Arthritis | convulsions/seizures | abdominal bloating | ----- |
| Irritability | loss of sleep | constipation | vision problem |
| Swollen joints | fatigue | diarrhea | hearing problem |
| Tail bone pain | nervousness | colitis/irritable bowel | abnormal sense of touch |
| Foot problems | loss of weight | heartburn or reflux | abnormal sense of taste/smell |
| Pain by shoulder blades | numbness/tingling | hemorrhoids | eye pain |
| Shoulder joint pain | allergy | liver problem | earache |
| Hernia | neuralgia | gall bladder problem | ear noises |
| Spinal curvature (scoliosis) | ----- | jaundice | sore throat |
| ----- | ----- | diverticulosis/itis | hoarseness |
| Abnormal heart rate | Skin problem | ----- | hayfever |
| High blood pressure | itching | frequent urination | ----- |
| Low blood pressure | bruises easily | painful urination | FEMALES: |
| Pain over heart | dry skin | blood or pus in urine | painful menstrual periods |
| Swelling of ankles | boils | bladder infection | excessive flow |
| Poor circulation | painful varicose veins | kidney infection or stones | irregular cycle |
| Stroke | hives or skin allergy | bed wetting | cramps or back pain |
| Other heart condition | shingles | inability to control urine | hot flashes |
| | | Prostate trouble | previous miscarriage |
| | | | Last menstrual period _____ |

I understand that I am personally responsible for all charges for services rendered.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT OR GUARDIAN'S SIGNATURE AUTHORIZING CARE (minors) _____