PRINT CLEARLY - FILL OUT COMPLETELY. THANK YOU!

NAME:_____ DATE: _____

ADDRESS: _____ APT. # _____ CITY: _____ STATE:_____ ZIP:_____

PHONE: (HOME) _____ (WORK) _____ (CELL) _____ E-MAIL ADDRESS:_____

SS#: _____ DATE OF BIRTH: _____ AGE: _____

MARRIED_____ SINGLE_____ DIVORCED_____ WIDOWED_____ NUMBER OF CHILDREN_____ REFERRED BY_____

DO OTHER FAMILY MEMBERS RECEIVE CHIROPRACTIC CARE? YES___ NO___ WHO?_____

YOUR OCCUPATION(S):_____ YEARS AT PRESENT JOB:_____

BUSINESS NAME/ADDRESS: _____

DO YOU HAVE HEALTH INSURANCE? YES_____ NO_____ NAME OF INSURANCE CO._____

PREVIOUS CHIROPRACTIC CARE? YES_____ NO_____ WHEN?_____ DOCTOR'S NAME:_____

PREVIOUS SPINAL X-RAY? YES_____ NO_____ WHEN?_____ REASON: _____

DID AN INJURY OCCUR? (Circle one) FALL / ON THE JOB / AUTO ACCIDENT / OTHER_____

DESCRIBE PRESENT COMPLAINT:_____

_____

_____

HAS THIS HAPPENED BEFORE? YES_____ NO_____ WHEN WAS THE FIRST OCCURRENCE?_____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? YES_____ NO_____ WHEN?_____ DESCRIBE:_____

_____

HAVE YOU EVER SUFFERED A FALL OR SERIOUS INJURY? YES_____ NO_____ WHEN?_____ DESCRIBE:_____

_____

HAVE YOU EVER HAD SURGERY? YES_____ NO_____ WHEN?_____ TYPE OF SURGERY/DESCRIBE:_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

ARE YOU PREGNANT? YES_____ NO_____ POSSIBLE_____ DATE OF YOUR LAST MENSTRUATION_____

DYNAMOMETER

DATE: _____

RIGHT HAND			
LEFT HAND			

PROGRESS REPORT

	DATE:	CA
1.		
2.		

PAMPHLETS

1 2 3 4 5 6 7 8 9 10

EXERCISE/STRETCHING ROUTINE

1 2 3 4 5 6 7 8 9 10

VIDEOS

	DATE:	CA
1.		
2.		

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? IF YES, CHECK THE BOXES BELOW.

- ❑ Headaches/Migraines
- ❑ Shooting Head Pains
- ❑ Sinus Trouble
- ❑ Allergies
- ❑ Hayfever
- ❑ Asthma
- ❑ Chronic Sore Throat
- ❑ Thyroid Trouble
- ❑ Twitching of Eye/Face
- ❑ Fatigue
- ❑ Depression
- ❑ Head Heaviness
- ❑ Dizziness
- ❑ Fainting
- ❑ Ringing in Ears (Tinnitis)
- ❑ Neck Pain
- ❑ Spasms in Neck/Shoulders
- ❑ Shoulder Pain
- ❑ Tightness in Shoulders
- ❑ Neuritis in Shoulders/Arms
- ❑ Grating in Neck (Noise)
- ❑ Pins & Needles in Arms/Hands
- ❑ Bursitis
- ❑ Cold Hands/Feet
- ❑ Shortness of Breath
- ❑ Tuberculosis
- ❑ Heart Palpitation
- ❑ High Blood Pressure
- ❑ Heart Attacks
- ❑ Low Blood Pressure
- ❑ Nervous Stomach
- ❑ Ulcers
- ❑ Nervousness
- ❑ Irritability
- ❑ Cold Sweats
- ❑ Liver Trouble
- ❑ Gall Bladder Trouble
- ❑ Indigestion
- ❑ Intestinal Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Colitis
- ❑ Sciatica
- ❑ Kidney
- ❑ Menstrual Cramps/Pain
- ❑ Irregularity
- ❑ Hernia
- ❑ Bladder Trouble/Cystitis
- ❑ Diabetes
- ❑ Cancer
- ❑ H.I.V. Positive
- ❑ Sleeping Problems
- ❑ Painful Joints, where?_____
- ❑ Knee Pain
- ❑ Arthritis, where?_____
- ❑ Slipped Disc
- ❑ Numbness, Pins & Needles in Buttocks/Thighs
- ❑ Ankle Pain
- ❑ Pains in Legs/Feet
- ❑ Low Back Pain
- ❑ Other_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE_____ **DATE** _____