PERSONAL HISTORY – *Please print. Fill out completely as these questions will assist the doctor in your treatment.*

Name _____ Home Phone _____ SS# _____

Address _____ City, State, Zip _____

Date of Birth _____ Age _____ Sex: (M) (F) # of Children_____ Marital Status_____

Cell/Pager/Email _____ Your Occupation_____

Business Phone _____ Spouse/Parent(s) Name _____

Prior Chiropractic Care? (Yes) (No) Referred By? _____ ☐May we Thank them?

Is your appointment for ☐Chiropractic Care ☐Nutritional Consultation

List your conditions or complaints in order of severity	Date Started or for how long	If you had this before, when?	Is this due to Injury?
1. _____	_____	_____	Yes No
2. _____	_____	_____	Yes No
3. _____	_____	_____	Yes No

Is this condition interfering with ☐Work ☐Sleep ☐Daily Routine ☐Personal Relationships ☐Sport/Exercise

What activities aggravate your condition? _____

What makes your condition better? _____

Is this condition getting progressively: Worse | Better | Staying the Same

Is this condition work related? Yes No Auto accident? Yes No Date of Injury/Accident _____

Other doctors seen for this or any health conditions?

1. Name_____ When _____ Is this your primary care provider? Y N
2. Name_____ When _____ Is this your primary care provider? Y N

What medications are you currently taking? _____

What vitamins are you currently taking? _____

List Surgeries

1. Type _____ When _____
2. Type _____ When _____
3. Type _____ When _____

List any allergies/Sensitivities you have? _____

Do you have any other complaints or conditions? _____

What do you expect our care to accomplish? _____

LIFESTYLE –PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

Diet: Are you restricting: Salt _____ Fat _____ Other_____
Liquids: Coffee, cups daily_____ Tea_____ Soda/Fruit Juice _____
Water Intake: cups daily _____
Sleep: Difficulty falling asleep Y N Daytime drowsiness Y N Other_____
Exercise routine: _____
Alcohol: Type_____ Amount_____ Recovering Alcoholic Yes No
Smoking: Packs daily_____ How long_____ Interested in stopping? Yes No
Stress: On a scale of 1-10 describe your stress level (1=none 10=extreme) Occupational _____/10 Personal _____/10

PLEASE CHECK ALL SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY SEEM UNRELATED TO YOUR CURRENT CONDITION:

☐Ringing in Ear_____
☐Ear Infections Frequent
☐Dizzy/Fainting
☐Failing Vision
☐Bleeding Gums
☐Nose Bleeds
☐Sinus Trouble
☐Sore Throats Frequent
☐Hayfever/Allergies
☐Pneumonia
☐Bronchitis/Chronic Cough
☐Asthma/Wheezing of cycle
☐Chest Pain
☐High Blood Pressure
☐Heart Murmur
☐Swollen Ankles
☐Leg Pain – Walking
☐Varicose Veins/Phlebitis
☐Loss of Appetite
☐Difficulty Swallowing
☐Indigestion/Heartburn
☐Persistent Nausea/Vomiting
☐Peptic Ulcers
☐Gall Bladder Trouble

☐Jaundice/Hepatitis
☐Change in Bowel Habit
☐Diverticulosis ☐Crohn's/Colitis
☐Diarrhea ☐Constipation
☐Bloody/Tarry Stools
☐Hemorrhoids
☐Hernia _____
Urination
☐Urine Infections Frequent
☐More than twice per night
☐Painful ☐Loss of Control
☐Decrease in force/flow
☐Blood In Urine
☐Kidney Stones
☐Venereal Disease
☐Chronic Fatigue
☐Weight Loss – Recent
☐Anemia ☐Bruise Easily
☐Cancer _____
☐Diabetes _____
☐Thyroid Disease _____
☐Convulsions/Seizures
☐Stroke
☐Frequent Infections

☐Tremor/Hands Shaking
☐Muscle Weakness
☐Numbness/Tingling Sensation
☐Headaches Frequent
☐Back Pain - Recurrent
☐Arthritis/Rheumatism
☐Osteoporosis
☐Bone Fracture/Joint Injury
☐Gout
☐Cold Numb Feet
☐Rashes ☐Hives ☐Dry Skin
☐Psoriasis ☐Eczema
☐Nervousness ☐Depression
☐Memory Loss
☐Moodiness – Excessive
☐Phobias
☐Mental Illness
☐Lactose Intolerance
☐Prostate Disease
☐Sexual/Menstrual Dysfunction
☐Chicken Pox ☐Polio ☐Mumps
☐Measles ☐Rubella
☐Scarlet Fever ☐Rheumatic fever
☐Tetanus ☐Herpes

☐Tuberculosis ☐Other_____

Females – Please Complete
Pregnant ☐Yes ☐No
Planning Pregnancy ☐Yes ☐No
Number of:
_____Pregnancies _____Miscarriages
Menstrual Flow:
☐Excessive ☐Irregular ☐Pain/Cramp
_____Days of Flow ____Length
First day of last period _____
☐Painful/Swollen Breasts
☐Flushing/Menopause
☐Pain/Bleeding during/after sex
Birth Control Method _____
Date of last PAP test _____
☐Normal ☐Abnormal
Date of last Mammogram _____
☐Normal ☐Abnormal

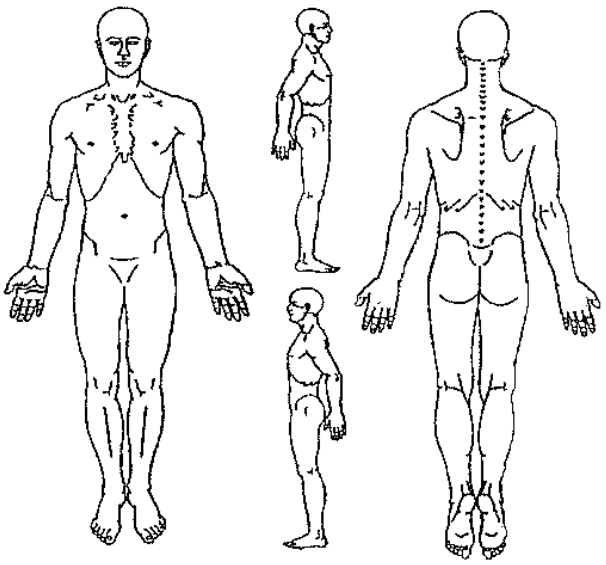
PLEASE CHECK IF ANY ONE IN YOUR IMMEDIATE FAMILY HAS HAD ANY OF THESE CONDITIONS:

☐Please check here if you were adopted and know no family history.

☐Diabetes ☐Cancer ☐Rheumatoid
☐Arthritis ☐Gout ☐Heart Disease
☐Stroke ☐Celiac Disease

Use the Letters listed below to indicate the type and location(s) of your pain and sensations:

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles
O = Other



Please Indicate the Level of Your Overall Pain

NO Pain **Severe Pain**

0 1 2 3 4 5 6 7 8 9 10

Who is Responsible for your bill: You and ☐Spouse/Parent ☐Medicare ☐Workers' Compensation ☐Other_____

Would you like us to submit claims to your health insurance or auto insurance? ☐Health Insurance ☐Auto Insurance ☐No

I clearly understand and agree all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend/terminate treatment, fees for professional services rendered me will be immediately due and payable. I am responsible for payment in full or payment of all deductible and/or co-payments and non-covered services at the time services are rendered. Cash, check and Visa/Mastercard are accepted. I am aware this office follows HIPAA regulations and if I wish to see the Notice of Privacy I may get a copy at any time.

Signature _____ Date _____
(Guardian Signature)

Reset Form Submit Form