

LAST NAME _____ FIRST NAME _____ MIDDLE _____
 ADDRESS _____ SS# _____ BIRTHDATE _____ AGE _____
 CITY _____ STATE _____ ZIP _____ DL# _____
 OCCUPATION _____ SPOUSE _____
 EMPLOYER _____ SPOUSE'S OCCUPATION _____
 # OF CHILDREN _____ PHONE _____ WORK _____ EMPLOYER _____
 cell _____ REFERRED BY _____
 email _____ contact in case of emergency _____

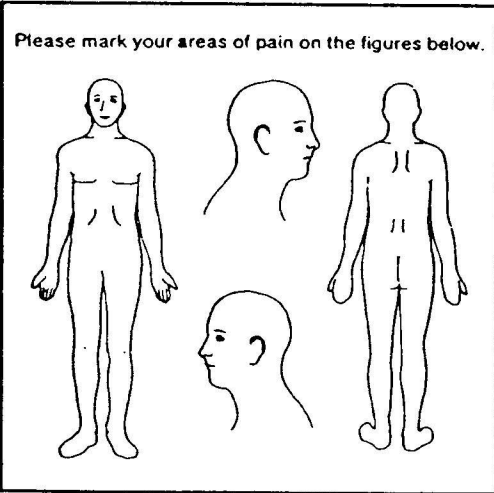
What is your major complaint? _____

Other complaints? _____

How long have you had this condition? _____ Have you had this or a similar condition in the past? _____

Did your accident occur while at work? Yes No When? _____

Is this condition getting progressively worse? Yes No Constant Comes and Goes



- Neck Problems
- Shoulder Problems
- Arm Problems
- Numbness-Arms
- Pain Between Shoulders
- Low Back Problems
- Leg Problems
- Numbness-Legs
- Loss of Feeling
- Stiff Joints
- Painful Joints
- Restricts Daily Activities
- Restricts Regular Exercise
- Sore Muscles
- Walking Problems
- Broken Bones
- Muscle Cramps
- Weak Muscles
- Headaches
- Dizziness
- Fainting
- Forgetfulness
- Depression
- Vision Problems
- Ear Pain/Noises
- Ear Infections
- Hearing Loss
- Frequent Colds
- Allergies
- Hay Fever
- Asthma
- Eczema
- Shingles
- Nausea
- Poor Digestion
- Ulcers
- Diarrhea
- Constipation
- Kidney Infection
- Menstrual Cramps
- Diabetes
- Blood Pressure High/Low
- Tiredness/Fatigue

- This is a new/old illness. It was not/was treated before. If treated before, what was done? _____
- Name of Doctors: _____
- Have you ever had surgery or been hospitalized? Yes No
List Surgeries: _____
- Have you ever had Chiropractic care before? Yes No
Name of Doctor _____ Date _____
- Last time you had spinal X-rays or other X-rays: _____
- Medications you now take: _____

- From birth to present please list by date/describe
- 1) Car Accidents _____
 - 2) Falls/Injuries (including Sports) _____
 - 3) Other _____

Past Medical History - circle and fill in

- Yes/ No Abnormal weight gain/loss
- Yes/ No Skin / Breast
- Yes/ No Eyes/Ears/Nose/Mouth/Throat
- Yes/ No Heart
- Yes/ No Lung /Asthma /Allergies
- Yes/ No Stomach / Intestinal
- Yes/ No Urinary /Kidney
- Yes/ No Ovary /Testes
- Yes/ No Neurological / Psychiatric
- Yes/ No Allergy /Asthma
- Yes/ No Endocrine: Diabetes/ hypo/hyper-thyroid
- Yes/ No Cancer /Seizure /Epilepsy
- Yes/ No alcohol /Tobacco
- Yes/ No Family history of cardiovascular /cancer/ diabetes/osteoporosis
- Yes/ No Hepatitis A / B/ C

Presenting Complaint

- Energy level: 1 to 10. 10 being great.
- Temp: hot/ cold whole body / hand and feet
- Thirst
- Appetite
- Digestion normal/ belch/ nausea/ vomit/ gas
- Urination: clear/ cloudy/ sl yellow/ blood
- Bowel normal /constipated /diarrhea 1x/2x/3x /day / week
- Sleep normal /Difficult Falling / Staying Asleep
- Anger/Worry/Sad/Fear/Depression/Anxiety
- Menses normal /cramps/ clots
- Post-menopause hot flashes day/night; sweat day/night