

Date: _____
 Name: _____ Referred By: _____
 Address: _____ City: _____ Zip: _____ Phone _____
 Birth date: _____ Sex: _____ Age: _____ Marital Status: _____ # of Children _____
 Occupation: _____ Employment _____ Work Phone#: _____
 Social Security Number: _____ Cell Phone # _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential)

MAJOR COMPLAINT _____

How long have you had this condition? _____

Date Began: _____

Have you lost work days? Yes No How Many? _____

Have you had this similar before? Yes No When? _____

Was The Injury related to: Work accident Auto accident

When did you last see a chiropractor _____ Dr.: _____

Why did you see this chiropractor? _____ Were you helped? _____

What spinal maintenance programs were you given to follow, to maximize the future stability of your spine? _____

Did you follow it? Yes No If not why? _____

Why are you changing chiropractors? _____

PAST (O) OR PRESENT (X) CONDITIONS:

- | | | |
|--|---|--|
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Mistake Sidedness (Rt. from Lt.) | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Stutter | <input type="checkbox"/> Heart problems |
| a. <input type="checkbox"/> 0-1 years ago | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Stroke |
| b. <input type="checkbox"/> 1-5 years ago | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> High or Low blood pressure |
| c. <input type="checkbox"/> More than 5 years ago | <input type="checkbox"/> Lose Temper Easily | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Other Accidents/Falls | <input type="checkbox"/> Headache | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Neck Pain or Stiff R. L. | <input type="checkbox"/> Gall Bladder trouble |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Numbness, Tingling, or Pain in arms, | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Mental or Emotional Disorders | hands or fingers | <input type="checkbox"/> Excessive gas |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Jaw Pain or Click (T.M.J.) R. L. | <input type="checkbox"/> Belching/bloating after meals |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Swollen or Painful Joints | <input type="checkbox"/> Head & Shoulders feel tired | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Convulsions/ Epilepsy | <input type="checkbox"/> Difficulty in excessive (standing, | <input type="checkbox"/> Diarrhea/ constipation |
| <input type="checkbox"/> Skin Problems | walking, sitting riding, bending, | <input type="checkbox"/> Colon trouble |
| <input type="checkbox"/> Itching | lifting, twisting, household duties) | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Shoulder pain R. L. | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Ringing in ears R. L. | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hearing loss R. L. | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Blurred or double vision R. L. | <input type="checkbox"/> Menstrual problems/PMS |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Upper back pain or stiffness R. L. | <input type="checkbox"/> Menopausal problems |
| <input type="checkbox"/> Excess Sweating | <input type="checkbox"/> Mid back pain or stiffness R. L. | <input type="checkbox"/> Breast lumps, soreness, discharge |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Lower back pain or stiffness R. L. | <input type="checkbox"/> Pregnant (currently) |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Numbness, tingling or pain in buttocks | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Allergy | thighs, legs, feet toes R. L. | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Pain with cough, sneeze or strain at | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Light Headed Upon Rising | stools | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Under Stress | <input type="checkbox"/> Hip pain R. L. | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Crave Sweets or Salt | <input type="checkbox"/> Foot trouble R. L. | Other _____ |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Chest pain | _____ |
| <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Difficulty breathing | _____ |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Lung Problems | _____ |
| <input type="checkbox"/> Loss of Memory | | |



