



Last Name: _____ First Name: _____ Middle Initial: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Street Address: _____

Mailing Address (if different): _____

City, State and Zip Code: _____

Age: _____ Date of Birth: _____ Social Security Number: _____

Sex: Male Female Number of Children: _____

Marital Status: Married Single Widowed Divorced

Occupation: _____ Employer: _____

Spouse's Name: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Driver's License Number: _____ State: _____

How did you hear about our office? _____

In case of emergency please contact: _____

Phone: _____

Please describe your condition(s) beginning with the most severe:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

When did this/these condition(s) begin? _____ The condition(s) is/are getting: Better Worse Same

What is the cause of your condition(s)? _____

What makes the condition(s) feel better? _____

What makes the condition(s) feel worse? _____



Have you seen any other physician for this condition? (if yes, please list name and dates)

Have you ever been treated by another chiropractor? (if yes, who/when/condition treated)

Have you ever had similar symptoms to present condition?

Are you currently being treated by any other physician? (if yes, please explain)

Please list your family physician and location (city, state):

Please list any medications you are currently taking:

Do you smoke? Yes No (if yes)____packs/day

Do you drink alcohol? Yes No (if yes)____drinks/week

Please list your complete surgical history (give dates and type of surgery):

Have you ever been involved in an automobile accident? (if yes, please give dates and explain accident):



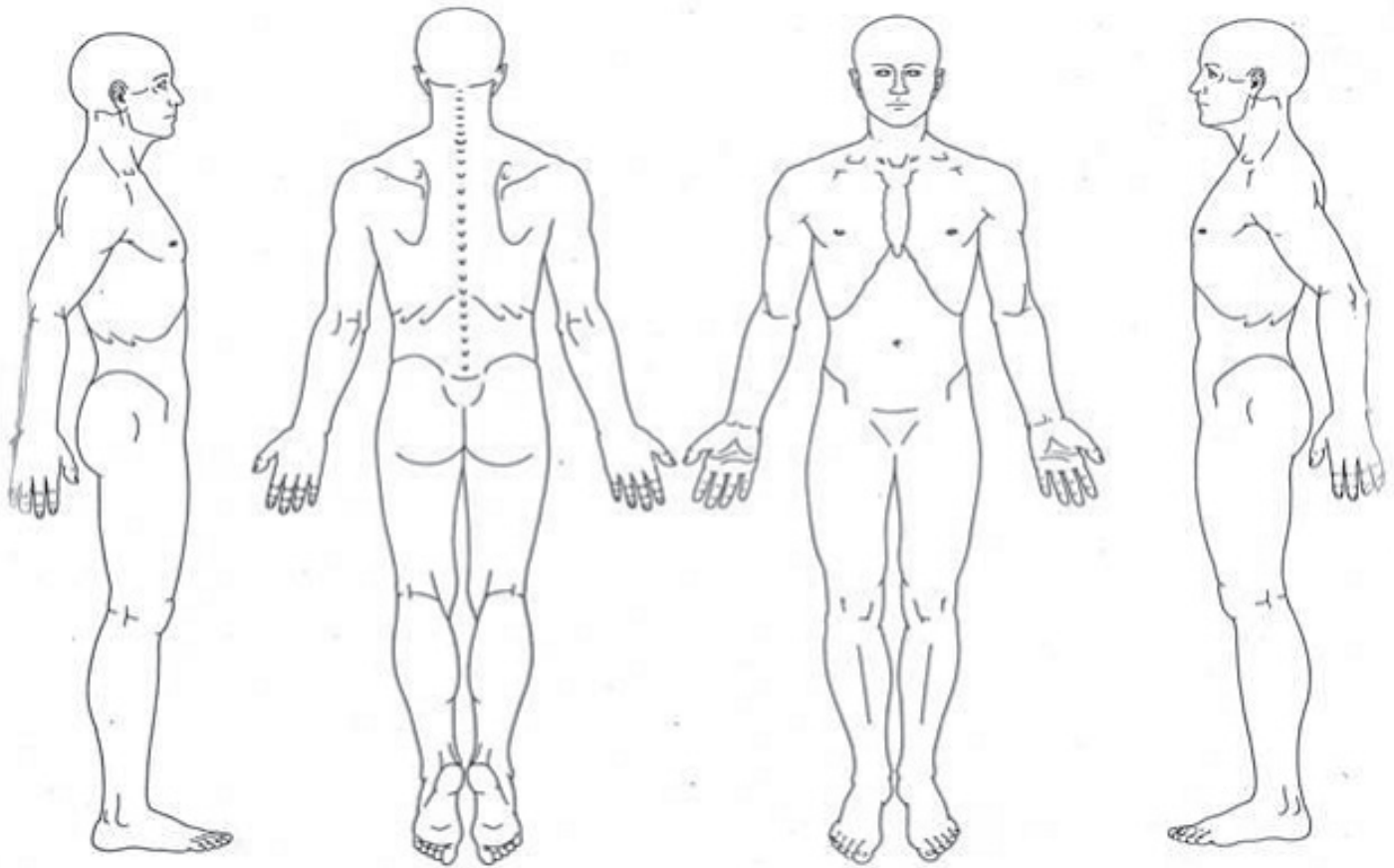
Name of person responsible for payment (if different from applicant):

Would you like us to file insurance for you? Yes No Have you met your deductible? Yes No

Name of insurance company (if applicable):

If you are experiencing any of the following symptoms, please indicate on the diagrams below:

A=ACHE B=BURNING N=NUMBNESS P=PAIN S=STABBING O=OTHER





Have you had any of the following diseases or medical conditions? (if yes, please check all that apply):

Pneumonia	Low Blood Pressure	Heart Disease	Mental Disorders
Rheumatic Fever	Measles	Thyroid Problems	Lower Back Problems
Polio	Mumps	Influenza	Frequent Neck Pain
Tuberculosis	Small Pox	Pleurisy	Eczema
Shingles	Chicken Pox	Arthritis	HIV/AIDS/ARC
Whooping Cough	Diabetes	Epilepsy	Hepatitis
Anemia	Cancer	Ulcers/Colitis	Emphysema
High Blood Pressure	Kidney Problems	Venereal Disease	Sinus Problems

Please review the following, and check all that apply:

Constitutional: No Issues Chills Weight Gain Weight Loss Drowsiness Fatigue Fever Night Sweats	Endocrine: No Issues Cold Intolerance Heat Intolerance Goiter Hair Loss Unusual Hair Growth Frequent Urination Diabetes Excessive Appetite Excessive Thirst Voice Changes
Eyes/Vision: No Issues Blindness Eye Pain Tearing Cataracts Change In Vision Blurred Vision Field Defect Wear Glasses/Contacts Glaucoma Itching	Nervous System: No Issues Dizziness Facial Weakness Headaches Limb Weakness Loss Of Consciousness Loss Of Memory Numbness Seizures Sleep Disturbances Stress Strokes Tremors Unsteadiness Of Gait Slurred Speech
Ears, Nose & Throat: No Issues Bleeding Headaches Snoring Ear Drainage Nose Bleeds (frequent) Dentures Hearing Loss Ringing In Ears Ear Pain Dizziness Nasal Congestion Dental Implants Head Injury Ear Infections Post Nasal Drip Sinus Infections TMJ Problems Fainting Loss Of Smell Sore Throat (frequent) Discharge Runny Nose Difficulty Swallowing Hoarseness	Allergy: No Issues History Of Anaphylaxis Itching Nasal Congestion Food Intolerance Sneezing
Respiratory: No Issues Asthma Coughing Up Blood Sputum Production Cough Shortness Of Breath Wheezing	Cardiovascular: No Issues Angina (Chest Pain) Claudication (Leg Pain) Heart Problems Orthopnea Palpitations Parox. Noct. Dyspnea Shortness Of Breath Ulcers Heart Murmur Swelling Of Legs Varicose Veins
Gastrointestinal: No Issues Abdominal Pain Nausea Belching Rectal Bleeding Hemorrhoids Constipation Vomiting Blood Jaundice (yellow skin) Difficulty Swallowing Abnormal Stool Heartburn Black, Tarry Stool Vomiting Indigestion Diarrhea Abnormal Stool Color	Skin: No Issues Changes In Nail Texture Hair Growth Itching Rash Skin Lesions/Ulcers Hair Loss Paresthesia History Of Skin Disorder Changes In Skin Color Hives Varicosities



Psychological:		No Issues	Female ONLY:		No Issues
Anhedonia (no pleasure)	Appetite Changes		Birth Control Therapy	Breast Lumps/Pain	
Confusion	Mood Changes		Burning Urination	Cramps	
Depression	Anxiety		Frequent Urination	Hormone Therapy	
Behavioral Changes	Insomnia		Irregular Menstruation	Urine Retention	
Bipolar Disorder	Memory Loss		Vaginal Bleeding	Vaginal Discharge	
Convulsions					
Hematology:		No Issues	Are you pregnant? Yes No		
Anemia	Easy Bruising		Date Of Last Period: _____		
Blood Transfusion	Blood Clotting				
Lymph Node Swelling	Fatigue		Male ONLY:		No Issues
Bleeding			Burning Urination	Erectile Dysfunction	
			Prostate Problems	Urine Retention	
			Frequent Urination	Hesitancy/Dribbling	

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____
 Adult Patient Parent/Guardian Spouse