

Doctor: _____ Patient number: _____

Name _____

Spouse _____

D.O.B. _____ Age _____ weight _____ lbs Home# _____ Work# _____

Occupation _____ e-mail _____ Cell# _____

What is your major complaint? _____ How long? _____

Mark below C =current of P past

- Neck Problems
- Shoulder Problems
- Arm Problems
- Numbness-Arm
- Problems between Shoulders
- Low Back Problems
- Leg Problems
- Numbness-Legs
- Loss of Feeling
- Stiff Joints
- Restricted Daily Activity
- Restricted Regular exercise
- Sore Muscle
- Walking Problems
- Broken bones
- Muscle Cramps
- Weak muscles
- Headaches
- Dizziness
- Fainting
- Upper back pain
- Mid back pain
- Knee/shoulder/wrist pain
- Shortness of breath
- High Blood Pressure
- Depression
- Vision Problems
- Ear Pain
- Ear Infection
- Hearing Loss
- Frequent Colds
- Allergies
- Hay Fever
- Asthma
- Eczema
- Shingles
- Nausea
- Poor Digestion
- Ulcers
- Diarrhea
- Constipation
- Menstrual Problems
- Diabetes
- Fatigue
- Migraines
- Anxiety
- Abdominal Pain
- Chest Pain
- Jaw Pain
- Sleep Problems

How did complaint originate? _____
 Is complaint getting worse? Yes ___ No ___
 Type of discomfort (circle one) sharp, dull, aching, numbness/tingling, burning, shoe stiffness, cramps, swelling, other: _____

How often do you experience the discomfort? (check one)
 ___ constantly ___ frequently ___ occasionally ___ intermittently ___ rarely
 Have you had this condition in the past? ___ yes ___ no if yes, explain: _____

What is your goal in our office? _____
 Have you ever seen a chiropractor before? ___ Yes ___ no if yes, explain: _____

What medications or drugs are you taken? (check all that apply): Pain Killers _____
 Insulin _____ Cholesterol Meds _____ Blood pressure Meds _____
 Muscle relaxers _____ Birth Control _____ Anitdepression/Anxiety _____
 Other: _____

Please list and describe:
 Car accidents: _____
 Falls/injuries and others: _____

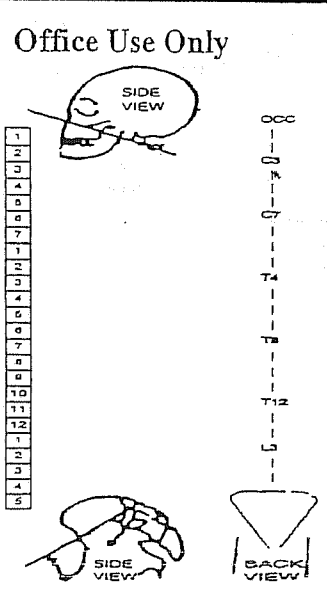
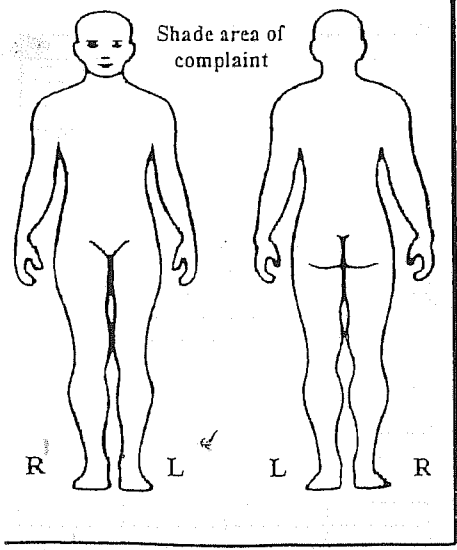
Indicate if an immediate family member has had any of the following:
 ___ Rheumatoid arthritis ___ Heart problems ___ Diabetes ___ Cancer ___ Lupus other ___

To your knowledge, have you had any diseases or major illness not indicated on this form from either in the past or the present:
 Yes ___ No ___ If yes please explain: _____

Family Physician: _____ Name of Facility: _____ Date of last visit: _____
 What operations have you had? _____ When? _____

I hereby attest that the above information and health history I have provided is complete and accurate, and that the doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor medical diagnoses.

Patient's/Gaurdian's signature : _____ Date: _____



1) X-Ray Date _____
 C-Curve _____ C-stress _____
 L-Curve _____ L-Stress _____
 2) X-Ray Date _____
 C-Curve _____ C-stress _____
 L-Curve _____ L-Stress _____

X-Ray Impression:

- FREQUENCY:
 C=Constant
 I=Intermittent
 O=Occasional
 IF=Infrequent
 D=Daily
 W=Weekly
- OTHER:
 PT=Patient
 HA=Headache
 TPT=Trigger point
 BL=Bilateral
 RT=Right
 LT=Left
 N=Neck
 UB=Upper Back
 MB=Midback
 LB=Low Back
 C=Cervical
 T=Thoracic
 L=Lumbar
 BGT=Body good today
- PAIN:
 1=Mild
 2=Moderate
 3=Severe
 4=Very Severe
 P=Pain
 S=Same
 ^=Improv
 W=Worse
 ST=Stable
 EX=Exercise
 TX=Treatment

Financial Plan/Insurance _____