☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Other _______ Date: ____________________

First Name ___________________ Middle Initial ____ Last Name________________________

Address Line 1 ____ City ____________________

State _____ Zip ___________ Cell Phone (____)__________________

Email _____________________________ Date of Birth ______/______/_______ Sex : M / F

Emergency Contact

Contact Name ____________________________

Relationship to Patient _________________________

Contact Home Phone (_____) _______-________ Cell Phone (_____) ________-___________________

How did you hear about our office? ____

Social History: (Check all that apply to you)
Drink Alcohol: ☐ occasional ☐ often ☐ never
Tobacco: ☐ occasional ☐ often ☐ never
Dietary History: (check all that apply)
I eat leafy greens ☐ daily ☐ weekly ☐ rarely/never
I drink at least five glasses of water ☐ daily ☐ weekly ☐ rarely/never
I eat fast food: ☐ daily ☐ weekly ☐ rarely/never
I eat red meat and dairy products: ☐ daily ☐ weekly ☐ rarely/never
I eat the recommended amount of fruits and vegetables: ☐ yes ☐ no ☐ sometimes
I take a high quality multi-vitamin: ☐ yes ☐ no Please list type/brand:_____________________

Please list all current medications or attach list:_______________________________________
____
____

Please list all supplements?
____
____

On a scale of 1-10, what is your overall level of stress?
Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Are finances a source of stress for you? Yes or No
Is your health a source of stress for you? Yes or No
Are your personal relationships a source of stress for you? Yes or No
Is sleeping or the lack of a source of stress for you? Yes or No
Is food a source of stress for you? Yes or No
Is your weight a source of stress for you? Yes or No

Are you pregnant? Yes_____ No ______N/A______

Family History: (Check all that apply)

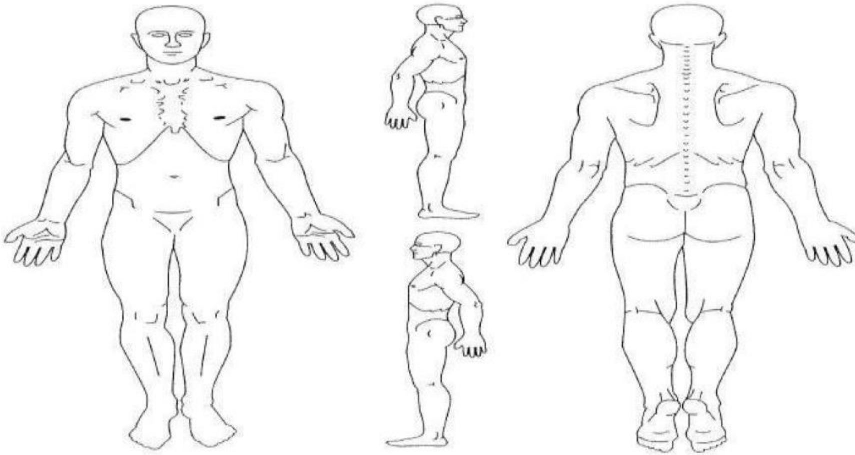
Arthritis: ☐ Parent ☐ Sibling
Diabetes: ☐ Parent ☐ Sibling
Hypertension: ☐ Parent ☐ Sibling
Other ___________________________

Cancer: ☐ Parent ☐ Sibling
Heart Disease: ☐ Parent ☐ Sibling
Stroke: ☐ Parent ☐ Sibling

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

	Past	Present	No		Past	Present	No		Past	Present	No
Cardiovascular				**Respiratory**				**Allergic/Immunologic**			
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol								**Ear, Nose and Throat**			
Pace Maker				**Psychiatric**				Difficulty Swallowing			
Jaw Pain				Depression				Dizziness			
Irregular Heartbeat				Anxiety				Hearing Loss			
Swelling of legs				Stress				Sore Throat			
								Nosebleeds			
Genitourinary				**Endocrine**				Bleeding Gums			
Kidney Disease				Thyroid				Sinus Infections			
Burning Urination				Diabetes							
Frequent Urination				Hair Loss				**Gastrointestinal**			
Blood in Urine				Menopausal				Gall Bladder Problems			
Kidney Stones				Menstrual				Bowel Problems			
Lower Side Pain								Constipation			
				Hematologic				Liver Problems			
Neurologic				Hepatitis				Diarrhea			
Lower Side Pain				Blood Clots				Nausea/Vomiting			
Stroke				Cancer				Bloody Stools			
Seizures				Bruising				Poor Appetite			
Head Injury				Bleeding				Nausea/Vomiting			
Brain Aneurysm				Fever, Chills				Poor Appetite			
Numbness				Sweating				Ulcers			
Severe Headaches											
Pinched Nerves				**Constitutional**				**Musculoskeletal**			
Parkinson's				Weight Loss/Gain				Joints Replaced			
Carpal Tunnel				Low Energy				Gout			
Vertigo				Sleep problems				Arthritis			
								Joint Stiffness			
								Muscle Weakness			
								Osteoporosis			
								Broken Bones			

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Rate your pain (circle one, 1=no pain, 10= bad pain): 1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? (mo/day/yr) __________________

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Describe your symptoms in order of severity, with worse symptom being #1: ______________________
____

Daily Activities: Effects of Current Condition on Performance (circle your answers)

Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Change Posn–Sit-Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform Extended
Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

I acknowledge that this chiropractic office does not take health insure or Medicaid, however I may file the paperwork myself for reimbursement, and will be given a receipt that has the appropriate coding to do so. I understand that payment is due at the time of service.

Print Patient's Name ____________________________________ Patient's

Signature____Date:_________