Patient Name _____ Date _____

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit

Are you in pain: ☐ Yes ☐ No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ☐ Work ☐ Sports/ play ☐ Auto Accident ☐ Routine/ Household activity

When did your condition/ accident occur? _____/_____/_____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is your condition interfering with your: ☐ Work ☐ Sleep or ☐ Daily routine? If so, how: _____

_____

Has this or something similar happened in the past?

☐ Yes ☐ No Explain: _____

_____

_____

Using the adjacent body charts, please circle all affected Areas.

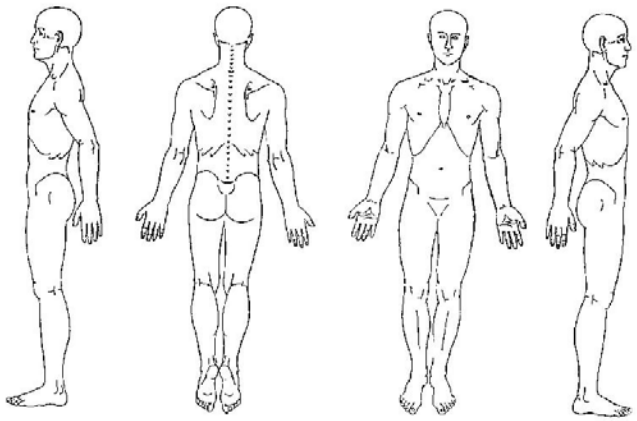
Have you been treated by a medical physician for this Pain? ☐ Yes ☐ No If so, where? _____

_____

Have you ever been treated by a chiropractor? ☐ Yes ☐ No

Clinic or Dr's Name: _____

Clinic Phone#: _____



Left Back Front Right

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain killers (including aspirin) ☐ Muscle relaxes ☐ Blood thinners

☐ Tranquilizers ☐ Insulin ☐ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke	Y N Heart/ Surg./ Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol/ Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N Anemia/ Diabetes
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Kidney Problems
Y N High/ Low Blood Pressure	Y N Psychiatric problems	Y N Rheumatic Fever	Y N Severe/ Frequent Headaches	Y N Tuberculosis
Y N Ulcers/ Colitis	Y N Fainting/ Seizures/ Epilepsy	Y N Sinus Problems	Y N Emphysema/ Asthma	Y N Arthritis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/ Joints/ Implants	

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above:

_____

_____

List any past serious accidents with dates:

_____

Please list anything that you may be allergic to:

_____

Patient Name _____ Date _____

Family Health History:

_____

Do you take Supplements or Vitamins? ☐ Yes ☐ No Do you exercise? ☐ No ☐ Yes _____ hours per week

Do you smoke? ☐ No ☐ Yes How much? _____ How Long? _____

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting: ☐ No ☐ Yes Since ____/____/____

For Women: Are you taking Birth Control? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best 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 other 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 or Guardian ☐ Spouse