Date: _____ Name: _____ Birthdate: _____

Home Phone: _____ Cell Phone: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Race: _____ Marital: M S W D How many children? _____ Spouse: _____

Occupation: _____ Employer: _____

Family Doctor: _____ How were you referred to our office? _____

Primary Insurance: _____ Secondary Insurance: _____

Medical History:

Have you had Chiropractic care before? NO – YES If yes, how long ago? _____

Have you been treated for your current condition? NO – YES If yes, Dr. _____

Prior MRI or X-Ray for current condition? NO – YES If yes when and where? _____

Have you had a broken bone? NO – YES If yes, please list _____

Have you ever had any major accidents? NO – YES If yes, what types? _____

Any artificial joints or electrical devices in your body? NO – YES Are you pregnant? NO – YES – Uncertain

To your knowledge, have you had any diseases, major illnesses, or injuries not already indicated on this form? NO – YES

If yes, please list and give year diagnosed: _____

Have you had any surgeries? NO – YES If yes, please list: _____

Are you taking any pain medications? NO – YES If yes, what and how often? _____

Are you experiencing any of the following? Unexplained Weight Loss -- Severe Night Pains -- Constant Fatigue

Dizziness -- Difficulty Swallowing -- Trouble with Speech -- Fainting -- Nausea -- Bladder Control Trouble -- Vertigo

Decreased Coordination -- Muscle Weakness -- Facial Numbness

Family History:

To your knowledge, has anyone in your close family had any major illnesses or diseases? NO – YES

If yes, please list and give dates diagnosed: _____

Work History:

Do you do any of the following at work currently?

Bending? NO – YES Driving? NO – YES Sitting? NO – YES Standing? NO – YES

Walking? NO – YES Lifting? NO – YES <10 lbs <20 lbs <50 lbs >50 lbs