PLEASE FILL IN BELOW

NAME____ DATE _____________________________

STREET __________________________________APT _______ CITY, ST _________________ZIP__________

HM PHONE: ___________________ WK PHONE: ___________________ CL PHONE: ___________________

GENDER: M ___ F ___ DATE OF BIRTH _________________ HEIGHT ____________ WEIGHT _________

MARITAL STATUS ____________ SS# _____________________ E-MAIL _____________________________

Give reason for seeking chiropractic care: ____
Describe: ____
____
How long have you had this problem? ____
Are you under the care of any other physician? Yes ______ No ______
If yes, please list the doctors you are seeing, the condition you are treated for and the progress of care to date:
____
____

Please list any medication you are presently taking and the reason for taking it: _____________________________
____
____
Please list all previous surgeries: ____
Please list any accidents, auto accidents, or broken bones you have had:_____________________________________
____
____
List any x-rays you have had in the last 2 years: ____
____

Have you been to a Chiropractor before? Yes _____ No _____ Date of last visit: ___________________________
How long were you under care? _____________________ Condition treated for: ___________________________
Name of Chiropractor: ____

Your occupation: ____
Duties you are required to perform regularly at work or home: ____
____

Habits:
Do you smoke cigarettes? Yes ___ No ___ # of packs per day: ____
Do you drink coffee? Yes ___ No ___ # of cups per day: ____
Do you consume alcohol? Yes ___ No ___ Approximately how much daily? ________________________________
Do you exercise regularly? Yes ___ No ___ if so, what forms and how much? ______________________________

Family Health History
Please describe the health of:
Father ____Mother ____
Spouse ______________________________________ Children, give ages ___________________________________

Who recommended this office to you? ***OR*** Where did you hear about our office? _____________________________

FEMALES: Is there a possibility of you being pregnant? ____

Have you EVER had any of the following? Please check:

___Hay Fever	___Gout	___Thyroid Trouble	___Tonsillitis	___Gall Bladder Trouble
___T.B.	___Pneumonia	___Heart Disease	___Appendicitis	___Liver Trouble
___Allergies	___Pleurisy	___Cancer	___Arthritis	___Diabetes
___Polio	___Asthma	___High Blood Pressure	___Hypoglycemia	___Rheumatic Fever
___Varicose Veins	___Bowel Trouble	___Hemorrhoids	___Ulcers	___Kidney Trouble
___Slipped Disc	___Epilepsy	___Venereal Disease	___Other ______________________________	

Are you PRESENTLY suffering from any of the following? Please check:

___headaches	___throat lumps	___palpitations of heart	___insomnia
___dizziness	___sore throat	___chest pains	___poor appetite
___nausea	___female problems	___back pains	___poor memory
___fainting	___cough	___hip pains	___inner tension
___change in vision	___shortness of breath	___leg pains	___nervousness
___nose bleeds	___indigestion	___neck pains	___blood in urine
___sinus pains	___heart burn	___shoulder/arm pains	___frequency of urination
___ringing in ears	___belching	___abdominal pains	___pain on voiding
___earaches	___vomiting	___other muscle pains	___cloudy urine
___ear discharge	___gas	___numbness	___change in weight
___impaired hearing	___constipation	___joint pains	___dry skin
___weakness	___diarrhea	___itching	___discoloration of skin
___fatigue	___rectal bleeding	___skin eruptions	___excessive sweating
___swelling of joints	___swelling of ankles	___ ________________	___ __________________

INSURANCE INFORMATION

Type of insurance: Regular Medical ___ Medicare___ Medicaid ___ Auto ___ Workers Comp ___

Name of Insured: ____ SS# _______________________________

Insured's Date of Birth: _______________________ Name of Employer: _____________________________________

Insurance Company: ____ Phone #: ____________________________

Insurance Company Address: ____

Policy # _________________________________ Group # ______________________ Claim # ____________________

Patient Name: ____ Today's Date _______________________________

Signature: ____ Relation to patient: _________________________