

Date: _____ Email Address _____

Name: _____ Referred by: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Birth date: ____/____/____ Age: _____

Marital Status S M W D No. of children _____ SS# _____ - _____ - _____ Occupation _____

Family Physician Name _____

MAJOR COMPLAINT: _____

How long have you had this condition? _____ Date Started: _____ Have you lost any workdays Yes () No ()

Was the injury related to: work accident () auto accident () _____

When did you last see a chiropractor? _____ Dr. _____ Were you helped? _____

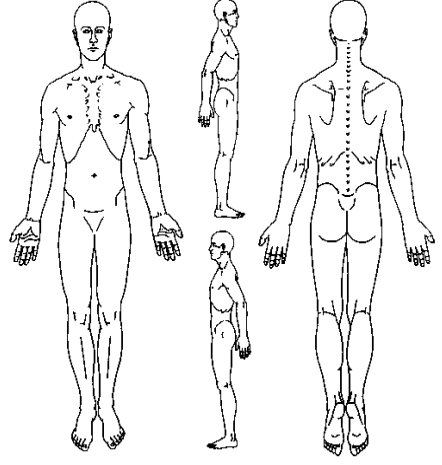
Surgeries have you had? _____

List medications that you are taking (prescription and non-prescription): _____

Please check the appropriate box for any of the following symptoms that you now have or have had previously. We want all the facts about your health before we accept your case.

- O-OCCASIONAL OF C GENERAL: Allergy, Dizziness, Fainting, Fatigue, Fever, Headache, Loss of sleep, Loss of weight, Nervousness/depression, Numbness, Sweats, Tremors, MUSCLE: Arthritis, Bursitis, Foot trouble, Low Back pain, Lumbago, Neck pain or stiffness, Shoulders, Arms, Elbows, Hands, Hips, Legs, Knees, Feet, Poor posture, Painful tailbone, Sciatica, Spinal Curvature, Swollen joints
F-FREQUENT OF C GASTRO-INTESTINAL: Belching or gas, Colon trouble, Constipation, Diarrhea, Difficult digestion, Gall bladder trouble, Distension of abdomen, Jaundice, Liver trouble, Nausea, Pain over stomach, Poor appetite, Vomiting, EYES, EARS NOSE, THROAT: Asthma, Colds, Crossed eyes, Deafness, Earache, Ear discharge, Ear noises, Enlarged Glands, Enlarged thyroid, Eye pain, Failing vision, Gum trouble, Hay fever, Nasal obstruction, Nosebleeds, Sore throat, Tonsillitis
O F C CARDIO-VASCULAR: Hardening of arteries, High blood pressure, Low blood pressure, Pain over heart, Poor circulation, Rapid heart beat, Slow heart beat, Swelling of ankle, RESPIRATORY: Chest pain, Difficulty breathing, Wheezing, SKIN: Boils, Bruise easily, Dryness, Varicose veins, Itching, Skin eruptions (rash), Hives or allergy
O F C GENITO- URINARY: Bed-wetting, Blood in urine, Frequent urination, Inability to control kidneys, Kidney infection or stones, Painful urination, Prostate trouble, Pus in urine, FOR WOMEN ONLY: Congested breasts, Cramps or backache, Excessive menstrual flow, Hot flashes, Irregular cycle, Menopausal symptoms, Painful menstruation, Vaginal discharge
YES NO ARE YOU PREGNANT?

Please mark your areas of complaint



CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- Alcoholism, Anemia, Appendicitis, Arteriosclerosis, Arthritis, Cancer, Cold Sores, Diabetes, Diphtheria, Eczema, Emphysema, Epilepsy, Fever blisters, GERD/Acid Reflux, Goiter, Gout, Heart disease, Influenza, Lumbago, Malaria, Measles, Miscarriage, Multiple sclerosis, Mumps, Pleurisy, Pneumonia, Polio, Rheumatic fever, Scarlet fever, Stroke, Tuberculosis, Typhoid fever, Ulcers, Venereal Disease, Whooping cough

Signature _____ Date _____