

Personal Information

Title: [ ] Mr. [ ] Ms. [ ] Mrs.
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Suffix: [ ] Jr [ ] Sr
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_
Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated
Address: \_\_\_\_\_ Apt # \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County/Parish: \_\_\_\_\_
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_
Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_

Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
Relationship: [ ] Spouse [ ] Relative [ ] Friend [ ] Other \_\_\_\_\_
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_
Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Employment Information

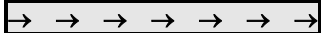
Business Name: \_\_\_\_\_
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
Employer's Email Address: \_\_\_\_\_
Occupation/Job Title: \_\_\_\_\_ Job Description \_\_\_\_\_

Current Health Condition

Unwanted Condition (Why you are here today?): \_\_\_\_\_

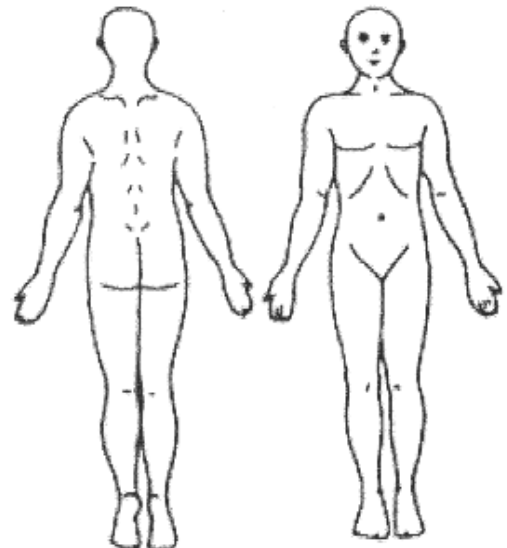
Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? \_\_\_/\_\_\_/\_\_\_
Has it ever occurred before? [ ] Yes [ ] No. When? \_\_\_\_\_
Is the Condition: [ ] Auto Related [ ] Job Related [ ] Home Injury
[ ] Slip or Fall [ ] Lifting [ ] Slept Wrong [ ] Unknown Cause [ ] Other
Explain: \_\_\_\_\_
Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am /pm
Condition/Pain STARTED on what Date: \_\_\_\_\_
Do you SUFFER with ANY OTHER Condition than which you are now consulting us?
\_\_\_\_\_
\_\_\_\_\_



**REVIEW OF SYSTEMS** -Below is a list of symptoms that may seem unrelated to the purpose of your appointment.  
However, these questions must be answered carefully as the problems can affect your overall course of care.

**Constitutional:**  I DENY having or have had any of the symptoms or problems listed below.

- |   |                                  |                                       |                                      |
|---|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> chills             | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> fever   | <input type="checkbox"/> weight gain  |                                      |

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- |   |   |                                     |  |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness      | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia           |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision    | <input type="checkbox"/> glaucoma   | <input type="checkbox"/> tearing               |
| <input type="checkbox"/> cataracts      | <input type="checkbox"/> eye pain         | <input type="checkbox"/> itching    | <input type="checkbox"/> wear glasses/contacts |

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- |  |  |   |   |  |
|--|--|---|---|--|
| <input type="checkbox"/> bleeding              | <input type="checkbox"/> ear drainage          | <input type="checkbox"/> hearing loss           | <input type="checkbox"/> nosebleeds                 | <input type="checkbox"/> sore throat                   |
| <input type="checkbox"/> dentures              | <input type="checkbox"/> ear pain              | <input type="checkbox"/> history of head injury | <input type="checkbox"/> postnasal drip             | <input type="checkbox"/> tinnitus<br>(ringing in ears) |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> fainting              | <input type="checkbox"/> hoarseness             | <input type="checkbox"/> rhinorrhea<br>(runny nose) | <input type="checkbox"/> TMJ problems                  |
| <input type="checkbox"/> discharge             | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> loss of sense of smell | <input type="checkbox"/> sinus infections           |  |
| <input type="checkbox"/> dizziness             | <input type="checkbox"/> headaches             | <input type="checkbox"/> nasal congestion       | <input type="checkbox"/> snoring                    |  |

**Respiration:**  I DENY having any of the symptoms or problems listed below.

- |                                 |  |  |
|---------------------------------|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood   | <input type="checkbox"/> sputum production |
| <input type="checkbox"/> cough  | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing          |

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure  | <input type="checkbox"/> shortness of breath<br>with exertion or exercise |
| <input type="checkbox"/> chest pain                        | <input type="checkbox"/> low blood pressure   | <input type="checkbox"/> swelling of legs                                 |
| <input type="checkbox"/> claudication (leg pain/ache)      | <input type="checkbox"/> orthopnea (difficulty breathing lying down)                              | <input type="checkbox"/> ulcers   |
| <input type="checkbox"/> heart murmur                      | <input type="checkbox"/> palpitations   | <input type="checkbox"/> varicose veins                                   |
| <input type="checkbox"/> heart problems                    | <input type="checkbox"/> paroxysmal nocturnal dyspnea<br>(waking at night w/ shortness of breath) |   |

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain       | <input type="checkbox"/> diarrhea              | <input type="checkbox"/> indigestion     | <input type="checkbox"/> abnormal stool<br>caliber  | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching             | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice        | <input type="checkbox"/> abnormal stool color       |   |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn             | <input type="checkbox"/> nausea          | <input type="checkbox"/> abnormal stool consistency |   |
| <input type="checkbox"/> constipation         | <input type="checkbox"/> hemorrhoids           | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting                   |   |

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> birth control     | <input type="checkbox"/> cramps             | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding  |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy              | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy    | <input type="checkbox"/> urine retention        |  |

**Male:**  I DENY having any of the symptoms or problems listed below.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> burning urination    | <input type="checkbox"/> frequent urination   | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention   |

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance   | <input type="checkbox"/> excessive hunger                | <input type="checkbox"/> goiter           | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes           | <input type="checkbox"/> excessive thirst                | <input type="checkbox"/> hair loss        | <input type="checkbox"/> voice changes       |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance |  |

**Skin:**  I DENY having any of the symptoms or problems listed below.

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss                 | <input type="checkbox"/> itching      | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color   | <input type="checkbox"/> hives                     | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities          |
| <input type="checkbox"/> hair growth             | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash         |  |

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> dizziness       | <input type="checkbox"/> limb weakness         | <input type="checkbox"/> numbness          | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor                                   |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures          | <input type="checkbox"/> stress         | <input type="checkbox"/> unsteadiness of gait/<br>loss of balance |
| <input type="checkbox"/> headache        | <input type="checkbox"/> loss of memory        | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes        |   |

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- |   |  |                                      |                                      |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia                  | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety                    | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression  | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion         | <input type="checkbox"/> insomnia    |                                      |

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis      | <input type="checkbox"/> itching                | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash                     |                                   |

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia   | <input type="checkbox"/> blood clotting    | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue         |  |

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

**Previous Care for Same Condition:**  I have not seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Was the treatment beneficial in resolving condition?  Yes  No

Explain: \_\_\_\_\_

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**Current Medication (s):** List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

**Childhood Illness (es):** LIST all health conditions. CIRCLE all CURRENT conditions.

- |   |  |                                    |   |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD                        | <input type="checkbox"/> chicken pox                 | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis          |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> crohn's/colitis             | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder   |
| <input type="checkbox"/> allergies/hay fever        | <input type="checkbox"/> depression                  | <input type="checkbox"/> HIV       | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia                     | <input type="checkbox"/> diabetes                    | <input type="checkbox"/> measles   | <input type="checkbox"/> spina bifida       |
| <input type="checkbox"/> asthma                     | <input type="checkbox"/> ear infections              | <input type="checkbox"/> mumps     | <input type="checkbox"/> other:             |
| <input type="checkbox"/> bedwetting                 | <input type="checkbox"/> fetal drug exposure         | <input type="checkbox"/> psoriasis |   |
| <input type="checkbox"/> cerebral palsy             | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash      |   |

**Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD             | <input type="checkbox"/> cystic kidney disease  | <input type="checkbox"/> hypertension                 | <input type="checkbox"/> psychiatric problems             |
| <input type="checkbox"/> alzheimers      | <input type="checkbox"/> depression             | <input type="checkbox"/> influenzal pneumonia         | <input type="checkbox"/> scoliosis                        |
| <input type="checkbox"/> anemia          | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease                | <input type="checkbox"/> seizures                         |
| <input type="checkbox"/> arthritis       | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease                 | <input type="checkbox"/> shingles                         |
| <input type="checkbox"/> asthma          | <input type="checkbox"/> eczema                 | <input type="checkbox"/> lupus erythema (discoid)     | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer          | <input type="checkbox"/> emphysema              | <input type="checkbox"/> lupus erythema (systemic)    | <input type="checkbox"/> STD's (unspecified)              |
| <input type="checkbox"/> cerebral palsy  | <input type="checkbox"/> eye problems           | <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> suicide attempt(s)               |
| <input type="checkbox"/> chicken pox     | <input type="checkbox"/> fibromyalgia           | <input type="checkbox"/> Parkinson's disease          | <input type="checkbox"/> thyroid problems                 |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease          | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo                          |
| <input type="checkbox"/> CRPS (RSD)      | <input type="checkbox"/> hepatitis              | <input type="checkbox"/> pneumonia                    | <input type="checkbox"/> other:                           |
| <input type="checkbox"/> CVA (stroke)    | <input type="checkbox"/> HIV                    | <input type="checkbox"/> psoriasis                    |   |

**Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> angioplasty             | <input type="checkbox"/> cosmetic         | <input type="checkbox"/> hysterectomy         | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy            | <input type="checkbox"/> D & C            | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff        |
| <input type="checkbox"/> caesarian section       | <input type="checkbox"/> dental surgery   | <input type="checkbox"/> joint replacement    | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder     | <input type="checkbox"/> knee repair          | <input type="checkbox"/> tonsillectomy       |
| <input type="checkbox"/> carpal tunnel repair    | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy          | <input type="checkbox"/> other:              |
| <input type="checkbox"/> coronary artery bypass  | <input type="checkbox"/> hernia repair    | <input type="checkbox"/> mastectomy           |  |

**Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> back injury      | <input type="checkbox"/> head injury (loss of consciousness)    | <input type="checkbox"/> motor vehicle accident        |
| <input type="checkbox"/> broken bones     | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild)     |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident                    | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe)    | <input type="checkbox"/> joint injury                           | <input type="checkbox"/> soft tissue injury (severe)   |
| <input type="checkbox"/> fracture         | <input type="checkbox"/> laceration (severe)                    | <input type="checkbox"/> other:                        |

**Family History: Mark all that apply below. List any specific conditions past or present after has/had:**

- |                      |                                |                                   |   |   |   |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

**Social History**

- Alcohol:  Never  Social Consumption only  Beer  Liquor  Wine ; \_\_\_\_ oz \_\_\_\_ glasses;  Day  Week  Month
- Diet (please mark all that apply):  High Fat  High Fiber  High Protein  High Salt  
 Low Calorie  Low Carb  Low Fiber  Low Salt  Low Sugar
- Education (please mark the highest level completed):  Preschool  Elementary  Middle  Junior High  Votech  
 In High School  Did Not Finish High School  High School Diploma  Post High School Classes  Assoc/Technical Degree  
 In College  College Degree  In Graduate School  Graduate Degree  Doctorate  Other: \_\_\_\_\_
- Drugs:  Deny any illegal drug use  Deny use of IV drugs  Have not used drugs since \_\_\_\_\_  Have used drugs for \_\_\_\_\_
- Tobacco:  Deny Tobacco Use  Do not smoke cigars, cigarettes or pipe  Live with a smoker  Quit smoking  
 Smoke; # \_\_\_\_\_ per  Day  Week  Month  Chew; # \_\_\_\_\_ cans per  Day  Week  Year

**Insurance Information:**

- Who Is Responsible For Your Bill?  YOU and... (mark appropriate box(es))  Myself ONLY
- Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Other (be specific): \_\_\_\_\_

**Workers Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ am/pm

