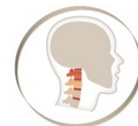

Confidential Patient Information

Name:_______________________________ ☐ Male ☐ Female Age:____ Date of Birth:_________________
Home Phone:__________________Cell Phone:____________________Work Phone:_________________
Address:____ City:_____________State:______ Zip:________
E-mail:____Social Security Number: _xxx_-_xx_-_________
Occupation:________________________________Employer:__________________________________
☐ Married (Spouse's Name__________________) ☐ Single ☐ Divorced ☐ Widowed
Children's Names/ Ages:____
Whom may we thank for referring you? ____
Emergency Contact Person:_____________________________ Phone Number:___________________
Have you had Chiropractic care before? ☐ No ☐ Yes- When/Where?______________________________
If you are leaving area for extended periods, when are you leaving:___________ Returning:________

HOW CAN WE SERVE YOU?

1. I have no complaints, I am here for a wellness check up. ☐

Subluxations (spinal misalignments) cause most of the unwanted health conditions people suffer from everyday. Subluxations affect your nervous system, which affects your health.

2. What is your first health concern?________________________ First occurrence date:___________
Subluxations irritate nerve fibers causing various sensations. Which describes yours?
☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching ☐ Stabbing ☐ Numbness ☐Other:___________________
Depending on the type and degree of subluxation, nerve pressure can be constant or occasional. How often is yours concern? ☐ Constant ☐ Occasional

3. What is your second health concern?____________________________ First occurrence date:___________
Subluxations irritate nerve fibers causing various sensations. Which describes yours?
☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching ☐ Stabbing ☐ Numbness
Depending on the type and degree of subluxation, nerve pressure can be constant or occasional. How often is your concern? ☐ Constant ☐ Occasional

Please list medications you are currently taking (prescriptions AND over the counter).
1.________________ 2._______________ 3._______________ 4.______________ 5.________________
Please list any/all surgeries: ____
____

Neurological
☐ headaches
☐ numbness, where?______
☐ Irritable
☐ nervousness
☐ tremors
☐ allergies
☐ seizures
☐ depression
☐ fatigue
☐ sleeping problems
☐ unexplained weight loss
☐ loss of balance
☐ dizziness

Gastro Intestinal
☐ diarrhea
☐ constipation
☐ colon trouble
☐ loss of bowel control
☐ difficult digestion
☐ acid reflux
☐ nausea/vomiting

Genito-Urinary
☐ bed wetting
☐ frequent urination
☐ loss of urine control
☐ kidney infection
☐ prostate trouble
☐ failing vision

Respiratory
☐ asthma
☐ chronic cough
☐ sleep apnea

Do You Have
☐ cancer
☐ heart disease
☐ diabetes

For Women Only
☐ menstruation
☐ infertility
☐ Pregnant
Due Date ______

Cardio-Vascular
☐ high blood pressure
☐ low blood pressure
☐ rapid heartbeat
☐ slow heartbeat
☐ swelling of the ankles
☐ chest pain

Eyes, Ears, Nose & Throat
☐ frequent cold
☐ hearing loss
☐ asthma
☐ ear aches
☐ ringing in the ears
☐ sinus infections
☐ thyroid trouble

OFFICE USE ONLY
M W T TH F
TIME:

REF________
NPE _______
CERx ______
LBx________

OFFICE USE:
Medicare ______
In____________
Other:_________

OFFICE USE ONLY

Patient Name: ______________________________________ **Date :**_____________________________

Health Concerns:

1. ____
   ____
2. ____
   ____
3. ____
   ____

Traumas:

1. **(MVA)**____
   ____
2. **(WORK)**____
   ____
3. **(HOME)**____
   ____
4. **(ACTIVITIES)**____
   ____
5. **(QOL)**____
   ____
6. **(GOALS)**____

Fee: $____________ **X-Ray: C T L F/E Other:**_________

C Spine____

T Spine____

L Spine____

Weight Distribution R________ **L**________

Leg Check: L R **Head Tilt: L R** **MOD SIG SEV**

Cervical Translation: L R **Shoulder: L R** **Hip Caliper: L R**