Date_____ Account Number_____

Patient Information

First Name_____ Middle Initial___ Last Name_____ Called Name_____

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

Birth Date_____ Social Security #_____

E-Mail_____

Marital Status (check one): [ ] M [ ] S [ ] D [ ] W Sex _____

Work Status: [ ] Employed [ ] Retired [ ] K-12 Student [ ] College Student [ ]Unemployed

Employer_____ Employer's Phone ( )_____

Employer's address_____City_____State_____Zip_____

Emergency Contact: Name_____ Phone Number ( )_____

Who may we thank for referring you?_____

Is today's visit related to employment? [ ] Yes [ ] No

Is today's visit related to an automobile accident? [ ] Yes [ ] No

Is today's visit related to another type of accident? [ ] Yes [ ] No

If you answered yes to any of the above, please give the state in which the accident occurred _____ and the date of the incident_____.

Referring physician _____

Major Complaints and Symptoms

Describe your symptoms _____

_____

_____

_____

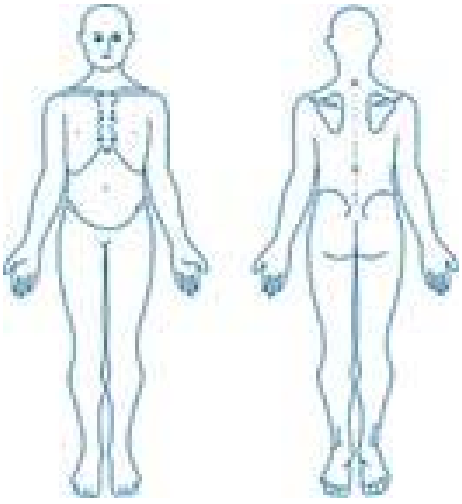
How often do you experience your symptoms? [ ] Constantly (76-100% of the day)
[ ] Frequently (51-75% of the day) [ ] Occasionally (26-50% of the day)
[ ] Intermittently (0-25% of the day)

What describes the nature of your symptoms? [ ] Sharp [ ] Dull Ache [ ] Numb [ ] Shooting
[ ] Burning [ ] Tingling

How are your symptoms changing? [ ] Getting Better [ ] Not Changing [ ] Getting Worse

Please describe the level of pain you have experienced on a scale of 0-10 with 10 being the worst pain you have ever experienced: [ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10.

How much time has your condition interfered with your social activities? [ ] All the time
[ ] Most of the time [ ] Some of the time [ ] None of the time
Please indicate where you have pain or other symptoms.



In general what would you rate your health right now [ ] Excellent [ ] Very Good [ ] Good
[ ] Fair [ ] Poor

Who have you seen for your symptoms? [ ] No one [ ] Other Chiropractor [ ] Medical Doctor
[ ] Physical Therapist [ ] Other: _____

Have you had similar symptoms in the past? [ ] Yes [ ] No

If yes, did you receive treatment [ ] Yes [ ] No

Have you had any test for your current condition? [ ] x-ray [ ] CT [ ] MRI [ ] Other: _____

Past Injuries

Please list any auto accidents you have been involved in, either as the driver or the passenger, below. Begin with the most recent.

Type of accident Type of treatment Date of accident

1. _____
2. _____
3. _____
4. _____

Please list any other job related, sport related or any other type of injury/accident. Begin with the most recent.

Type of injury Type of treatment Date of injury

1. _____
2. _____
3. _____
4. _____

Medications

Please list all medications you are currently on and the condition they are taken for.

1._____
2._____
3._____
4._____
5._____

Health History

Are you pregnant? [ ] Yes [ ] No Due Date _____

Place a check mark on "Yes"

AIDS/HIV [] Yes	Headaches [] Yes	Polio [] Yes
Alcoholism [] Yes	Heart Disease [] Yes	Prostate Problem [] Yes
Allergy Shots [] Yes	Hepatitis [] Yes	Prosthesis [] Yes
Anemia [] Yes	Hernia [] Yes	Psychiatric Care [] Yes
Ankle Pain [] Yes	Herniated Disk [] Yes	Rheumatoid Arthritis [] Yes
Anorexia [] Yes	Herpes [] Yes	Rheumatic Fever [] Yes
Appendicitis [] Yes	High Blood Pressure [] Yes	Scarlet Fever [] Yes
Arthritis [] Yes	High Cholesterol [] Yes	Shoulder Pain [] Yes
Asthma [] Yes	Hip Pain [] Yes	Sinus Problems [] Yes
Bleeding Disorders [] Yes	Irritable Bowel Syndrome []Yes	STD's [] Yes
Breast Lump [] Yes	Kidney Disease [] Yes	Stroke [] Yes
Bronchitis [] Yes	Knee Pain [] Yes	Suicide Attempt [] Yes
Bulimia [] Yes	Liver Disease [] Yes	Thyroid Problems [] Yes
Cancer [] Yes	Low Back Pain [] Yes	Tonsillitis [] Yes
Cataracts [] Yes	Measles [] Yes	Tuberculosis [] Yes
Chemical Dependency [] Yes	Mid-Back Pain [] Yes	Tumors, Growths [] Yes
Chicken Pox [] Yes	Miscarriage [] Yes	Typhoid Fever [] Yes
Diabetes [] Yes	Mononucleosis [] Yes	Ulcers [] Yes
Elbow Pain [] Yes	Multiple Sclerosis[] Yes	Upper Back Pain [] Yes
Emphysema [] Yes	Mumps [] Yes	Vaginal Infections [] Yes
Epilepsy [] Yes	Neck Pain [] Yes	Whooping Cough[] Yes
Fractures [] Yes	Osteoporosis [] Yes	Wrist Pain [] Yes
Glaucoma [] Yes	Pacemaker [] Yes	Other _____
Goiter [] Yes	Parkinson's Disease [] Yes	
Gonorrhea [] Yes	Pinched Nerve [] Yes	
Gout [] Yes	Pneumonia [] Yes	

Patient Signature_____ Date:_____

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