Confidential Patient Information

Welcome To Auerbach Family Chiropractic Center!

Name_____ Phone _____ Cell_____
Street Address_____ Email:_____
City_____ State_____ Zip_____ Date of Birth _____
Please Check ✔ Sex: Male_____, Female _____ Marital Status: S M W D # of Children_____
Who referred you, or how did you hear about us?_____ SS#_____

Personal & Family History: Occupation:_____ Employer:_____
Employer Address:_____ Phone:_____
Spouse's Name:_____ Employer:_____ Phone:_____

Health History:

Is this a wellness visit ____, or for a specific concern? _____ Explain:_____
Describe any health concerns, including when & how they began:_____

What area(s) of your life has this problem affected the most? Family___ Relationships___ Work___ Exercise___ Recreation___
What activity does this problem prevent you from doing, either partially or totally, that you would really like to do? _____

Are you under the care of any other doctor? Yes___ No ___ Primary Care Dr's Name:_____
If Yes, the conditions being treated for: _____
List any current Medications:_____
List any past surgeries & dates:_____
List any past accidents & dates:_____
List any x-rays in the past 2 years:_____

Chiropractic History: Have you ever been to a Chiropractor before? Yes ___ No___ If Yes, Date of Last Visit_____
Chiropractor's Name:_____ Reason for care_____

Check if you have had or if you currently suffer from the following:

Condition	*Occasional*	*Frequent*
Headache	_____	_____
Migraines	_____	_____
Neck Pain	_____	_____
Shoulder Pain	_____	_____
Arm/Hand Pain	_____	_____
Mid Back Pain	_____	_____
Low Back Pain	_____	_____
Hip Pain	_____	_____
Leg/Foot Pain	_____	_____
Jaw Pain	_____	_____
Disc Problems	_____	_____
Arthritis	_____	_____
Joint Swelling	_____	_____
Numbness	_____	_____
Dizziness	_____	_____

Condition	*Occasional*	*Frequent*
Nausea	_____	_____
Chest Pains	_____	_____
Cough	_____	_____
Weakness	_____	_____
Fatigue	_____	_____
Nervousness	_____	_____
Insomnia	_____	_____
Vision Changes	_____	_____
Nose Bleeds	_____	_____
Ringing in Ears	_____	_____
Earaches	_____	_____
Hearing Loss	_____	_____
Frequent Colds	_____	_____
Allergies	_____	_____
Asthma		

Condition	*Occasional*	*Frequent*
Digestive Problems	_____	_____
Urinary Problems	_____	_____
Skin Conditions	_____	_____

Possibly Pregnant? Yes_____ No_____
Other : _____
Smoker? ____Pk/Day____ Alcohol/How Often?_____
Substance Use?_____ Abuse?_____

- Check If Yes For You And/Or Family Member:

Diabetes - You: _____ Family-Who?_____
Gout - You: _____ Family-Who?_____
Cancer-You: _____ Family-Who?_____
Osteoporosis-You: _____ Family-Who?_____
Hypoglycemia -You: _____ Family-Who?_____
Heart Problems-You: _____ Family-Who?_____
Lung Problems- You: _____ Family-Who?_____

- Other:_____

Present Health Goals:

___ Improve Nutrition/Eating Habits
___ Weight Loss/Fat Loss
___ Increase Lean Muscle Mass
___ Increase Bone Density
___ Reduce Stress
___ Lower Cholesterol
___ Lower Blood Pressure
___ Start Exercising
___ Look Better
___ Feel Better
___ Get Off Medications
___ Improve Sleep
___ Improve Energy
___ Improve Posture
___ Improve Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you're doing in the following categories:
Exercise Sleep Diet Stress Level Water Intake Energy Level

Your Signature:_____ **Date:**_____