FONKE
CHIROPRACTIC AND
DECOMPRESSION CENTER

Health History

NAME ____ **DATE** ______________

ADDRESS _________________________ **CITY/STATE/** ______________ **ZIP**_______

HOME PHONE ______________________ **MOBILE PHONE** ___________________________

WORK PHONE/S ____________________**BIRTHDATE** ______________**SS#**___________

OCCUPATION ______________________ **EMPLOYER** ______________________________

ADDRESS _________________________ **CITY/STATE** _______________ **ZIP** _________

SPOUSE __________________________**CHILDREN (NAMES/AGES)** _________________

E-MAIL ADDRESS ____

WHO REFERRED YOU TO US? ____

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION ______________________

____ **LAST VISIT** __________

CURRENT MEDICAL CARE? YES/NO WHY? ______________________________________

CURRENT DRUGS/MEDICATION ____

DO YOU SMOKE? YES/NO IF YES, HOW MUCH____________________________________

DO YOU DRINK ALCOHOL YES/NO IF YES, HOW MANY DRINKS PER DAY? _______

REASON FOR CONSULTING THIS OFFICE ____

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PLEASE CHECK THE <u>ONE</u> CHOICE THAT MOST CLOSELY DESCRIBES

WHAT YOU ARE LOOKING FOR

❑ I am only concerned about relief of a particular symptom.

❑ I am concerned about relief of a particular symptom and preventing its return.

<u>WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD</u>

I understand that all services are to be paid in full at the time of service,
unless other arrangements have been made and agreed upon in writing.

Signature ____Date ____________________

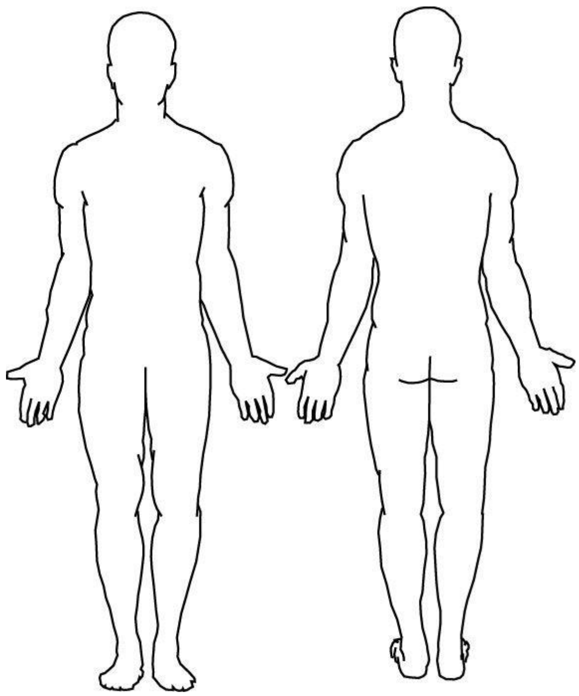
Name and Date ________________________________

MARK SYMPTOMS ON DIAGRAM

XXXXXXXXXXX Pain
//////////////////////// Numbness
000000000000 Tingling
############ Burning
^^^^^^^^^^^^^ Weakness

Pain Scale (1= little pain)

Current 1 2 3 4 5 6 7 8 9 10
@ Worst 1 2 3 4 5 6 7 8 9 10
@ Best 1 2 3 4 5 6 7 8 9 10



PLEASE TELL US ABOUT ANY STRESS UP TO PRESENT:

- ❑ **Auto Accident or Injury?**
- ❑ **Work Injury?**
- ❑ **Sports Injury?**
- ❑ **Work Stress?**
- ❑ **Family/Home Stress?**
- ❑ **Prescription Drug Use?**
- ❑ **Non-Prescription Drug Use?**
- ❑ **Ever Hospitalized?**
- ❑ **Surgery?**
- ❑ **Any Major Illness?**
- ❑ **Reoccurring Illnesses?**
- ❑ **Limited Exercise?**
- ❑ **Poor Nutrition?**

Explain ________________________________
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Anything else? ____

To be filled out by office staff

BP______/______P_______ Signature________________________