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 _____

_____

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.

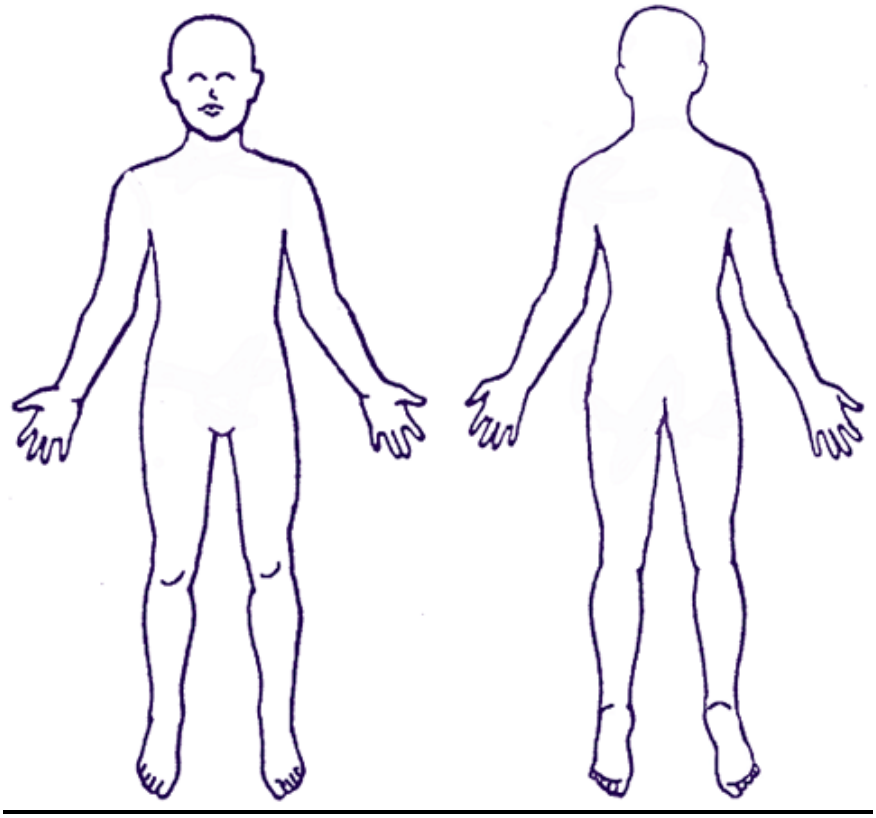
Signature _____ Date _____

MARK SYMPTOMS ON DIAGRAM

Pain Scale (1= little pain)

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

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?** **Explain** _____
- ❑ **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?** _____

Anything else? _____

_____