Confidential Case History

How do you wish to be addressed in our office? □ First name □ nickname □Mr. □Mrs. □Ms. □Miss □Dr.

Full Legal Name _____ □Male □Female

Date of Birth _____ Age _____ Email: _____

Address _____ Apt. ____ City _____ Zip code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Occupation _____ Employer _____

□Married □Single □Divorced □Widowed How Many Children _____

Spouse's Name _____ Phone number _____

How did you happen to choose our office? _____

Have you ever been to a chiropractic doctor before? □Yes □No If Yes, when was your last visit? _____

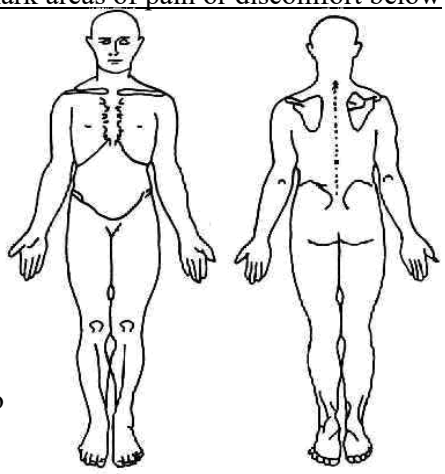
What is your major complaint? _____

_____

_____

List other doctors seen for this condition: _____

Please mark areas of pain or discomfort below



Do you frequently suffer from any of the following?

□Asthma	□Headaches	□Dizziness
□Backache	□Migraines	□High Blood Pressure
□Neck Pain	□Digestive Upset	□Blurred Vision
□Allergy	□Constipation	FEMALES ONLY:
□Arthritis	□Sleep Problems	□Painful menstruation
□Low Energy	□Depression	□PMS
□Foot Pain	□Sinus Trouble	Are you pregnant? □Yes □No

Do you feel you are: □overweight, □underweight, □ideal weight?

Additional information: _____

_____

- I understand that payment is due at the time services are rendered.

Signature: _____ Date: _____