First Name and Middle Initial | Last Name | Birth Date | Height and Weight (lbs)

Nickname or how you prefer to be addressed | Gender: ☐ Male ☐ Female ☐ Other | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Your Name if patient is a minor | Your Date of Birth | Relationship to the patient

Residence Address | City | State | ZIP

Mailing or Billing Address (if different from Residence Address) | City | State | ZIP

Home Phone | Cell Phone | Cell Phone Carrier | E-mail Address

Spouse Name | Spouse Phone | Emergency Contact (if other than spouse) | Phone | Relationship

Occupation | Employer | Years at current job | Who can we thank for referring you?

What prompted you to seek care today (you may have more than one complaint so please start with your primary concern).

Complaint: _____

What does it feel like? ☐ Aching ☐ Burning ☐ Cramps ☐ Dull ☐ Nagging ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stiffness ☐ Throbbing ☐ Tightness Other:

Frequency: ☐ Constant (75-100% of time) ☐ Frequent (50-74%) ☐ Occasional (25-49% of time) ☐ Intermittent (less than 25%)

Are your injuries due to a work injury? ☐ Yes ☐ No Have you filed a claim yet? ☐ Yes ☐ No

Are your injuries due to a motor vehicle accident? ☐ Yes ☐ No Have you filed a claim yet? ☐ Yes ☐ No

Do you have any form of Medicare insurance? ☐ Yes ☐ No Do you have any form of Medicaid insurance? ☐ Yes ☐ No

Are there any other concerns you have or want the doctor to know about?

Please list your previous chiropractic care. Include the doctor/location:

When were you last seen? _____ How long were you under care? _____ Number of visits? _____

Reason for discontinuing? _____ Any prior problems with adjustments? _____

Current Medications, Vitamins and Supplements; Include Dosage	**Please list any allergies to food, medication and other factors**

Please list ALL surgeries, prior injuries & year of each

Family History – Blood related relatives and conditions like: Arthritis, High Blood Pressure, Heart Disease, Cancer, Diabetes, Multiple Sclerosis, Other

Review of Systems – Please check if you have any of the following NOW or IN THE PAST.

☐ Headache ☐ Fatigue ☐ Arthritis ☐ Stroke ☐ Shingles ☐ Swollen joints ☐ Nervousness ☐ Pregnant at this time ☐ Multiple sclerosis ☐ Spinal curvature
☐ Cancer ☐ Dizziness ☐ Diabetes ☐ Sinus ☐ Migraine ☐ Heart Attack ☐ Carpal tunnel ☐ High Blood Pressure Other:_____

☐ Never a smoker ☐ Former Smoker--Quit in_____year ☐ Current every day smoker _____packs per day ☐ Current periodic smoker. How often_____

Do you drink alcohol? ☐ none ☐ casual ☐ moderate ☐ heavy ☐ drinks wine ☐ drinks beer Caffeine? ☐ none ☐ <3 drinks/day ☐ 3-6 drinks/day ☐ >6 drinks/day

Exercise? ☐ never ☐ daily ☐ weekly ☐ walks ☐ runs ☐ swims ☐ Other_____

Pain relievers ☐ Daily ☐ Weekly How much? _____ What kind? _____

Water intake ☐ Daily ☐ Weekly How much? _____

By signing below, I certify that the information I provided above is accurate to the best of my knowledge.

Signature | Today's Date