INITIAL FORM

Name _____ **SS #** _____ **Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home # _____ **Cell #** _____ **Work #** _____

DOB _____ **Age**_____ **Sex: M F** **Children** _____ **Marital Status: S M W D**

E-Mail _____ **Place of Employment** _____

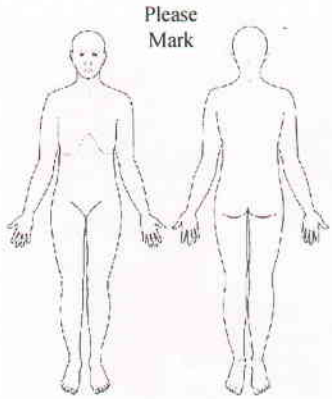
How were you referred to our office? _____

Have you ever been to a chiropractor before? _____

Please describe your symptoms_____

_____

_____



When did your symptoms start? _____

How often do you experience your symptoms?

◯ Constantly ◯ Frequently ◯ Occasionally ◯ Intermittently

What describes the nature of your symptoms?

◯ Sharp ◯ Dull Ache ◯Numb/Tingling ◯ Shooting ◯ Burning ◯ Other_____

How are your symptoms changing? ◯ Getting Better ◯ Not Changing ◯ Getting Worse

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During the <u>past 4 weeks</u>:

What is the average intensity of your symptoms? (Please Circle) **None 1 2 3 4 5 6 7 8 9 10 Unbearable**

How much has the pain interfered with your normal work and/or social activities?
(Including work outside the home, housework, visiting with friends, etc.)

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

Please list any other doctors consulted for this problem_____

Is this injury related to: Auto Accident_____ **Work Injury**_____

Females: Are you pregnant? Yes_____ **No**_____ **Not Sure**_____

Today's services will be handled by: Cash_____ **Check**_____ **Visa/MC**_____

Patient's Signature:_____ **Date:**_____