

Patient	Number	
		(office use only)

Toda	v's	Date:	
	, -		

Have you consulted a chiropractor before? ○ No ○ Yes

Whom may we thank	for referring	you?			Wh	en?	If so	, Where?	
First Name		MI	Last Name			Birtho	late	Age	Gender OM O F
Address			ity				State	Zip]
Cell Phone	H	ome Pho	none Work Phone		Social Security #				
E-mail Address					Employe	r			
Marital Status O Single O Married O Other	○ Widowe	d	Spouse Nar	ne	# of Ch	ildren	Ages ○ 0-5 ○ 5-10	0 010-18	O Adult
Primary Language O English O Spanish O Other	Tobacco O Smok O Chew O None	e C	referred Commun) Cell Phone) Home Phone) Work Phone) E-mail	ication	Method of p O Cash O Check O Credit C		you plan to use to	take care of	today's charge
Emergency Contact			ergency Contact'	s Phone	Prima	Primary Physician			
cknowledgements set clear expectations, improve		and help yo	u get the best results in	n the shorte	est amount of time	e, please re	ad each statement and	initial your agre	ement.
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I am interested in:		OStretches and Exercise O Wellness Care	○ Nutritional Advice ○ Quit Smoking	Mechanism Intensity Frequency
Please state your rea	son for coming in today.			Radiation AF RF
				Past Episodes
2.				
				<u>-</u>
Have you had any s	pinal, arm or leg surgeries?	○ No ○ Yes		Const

Vitals: (completed by staff)
H:
W:
P:
BP:
BMI:
T:
R:

Patient Name:	Patient Number (office use):		
Review of Systems	Past Medical History	List Prescription Medications (We	
Diagon should be side a pay a support of		can happily make a copy of your list	
Please check beside any current or	Illnesses	instead of writing here)	
past concerns	O Diabetes		
O Neck Problems	O Cancer O Epilepsy		
O Back Problems	O Epilepsy O Multiple Sclerosis		
O Joint Problems	O Stroke		
O Scoliosis	O Heart Disease		
O Swollen Joints	O Shingles	List Vitamins and Supplements	
O Arthritis	O Other		
O Anxiety/Depression	O None		
O Weakness			
O Headache/Migraines	Operations		
O Dizziness	 Cardiovascular Surgery 	p-,	
O Numbness/Tingling	O Cancer	Is there anything else we should	
O High Cholesterol	O Other	know?	
O High Blood Pressure O Asthma	O None		
O Seasonal Allergies	Family History		
O Shortness of Breath	Family History		
O Emphysema or COPD	O Stroke O Cancer		
O Abdominal Pain	O Cancer O Cardiovascular Disease		
O Kidney Stones	O Diabetes		
O Constipation	O Other		
O Diarrhea	O None		
	Social History		
	Exercise		
	, O Daily O Weekly		
	O Never/Not Much at All		
	Tobacco Use		
	O None		
	O Smoke		
	Smokeless		