WELCOME

Email: _____

Referred By _____

Name _____ Telephone (____) _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex: M F Status: M S W D SS# _____

Occupation _____ Employer _____ Work Phone (____) _____

Spouse/Parent _____ Occupation _____ Employer _____

Parent/Guardian signature authorizing care for minor _____

Name of Children/Ages _____ Current M.D. _____

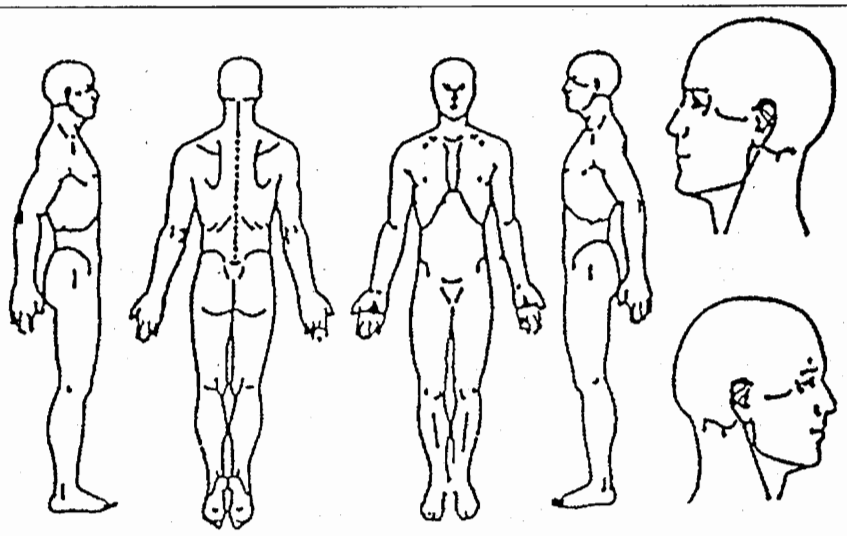
FEMALES: Are you pregnant or any chance you could be? ❑ Yes ❑ No Last Menstrual Cycle _____

Reason for today's visit _____

How & when did problem begin _____

_____

MARK ON DIAGRAM LOCATION OF PROBLEMS



DO YOU CURRENTLY SUFFER FROM ANY OF THE FOLLOWING?

IF NO, CHECK HERE ■

❑ Blurred Vision	❑ Vertigo	❑ Weight Loss
❑ Dizziness	❑ Nausea	❑ Loss of Balance
❑ Ringing/Buzzing in Ears	❑ Vomiting	❑ Faintness
❑ Light-headedness	❑ Fever	❑ High Blood Pressure
❑ Slurred Speech	❑ Sweats	❑ Hardening of Arteries
❑ Difficulty Swallowing	❑ Chills	❑ Cardiovascular Disease

Have you ever had Chiropractic care before? ❑ No ❑ Yes Date of last adjustment? _____

Chiropractors you have seen before: Name _____ Name _____

Medical/Orthopedic Doctors you have seen for this condition:

Name _____ When? _____ Diagnosis? _____

Name _____ When? _____ Diagnosis? _____

What diagnostic tests have you had for this condition? ❑ X-Rays ❑ CT Scan ❑ EEG ❑ MRI ❑ EMG ❑ Other_____

Surgical Operations/Dates _____

_____

Please Continue on Back

LIST ALL CURRENT MEDICATIONS/DIET SUPPLEMENTS AND AMOUNTS:

(Include aspirin, motrin, acetaminophen, ibuprophen, birth control, antibiotics, etc.)

_____

_____

DATE OF LAST:

	Less than 6 mos.	6-18 mos.	Over 18 mos.	Never
Physical examination	❑	❑	❑	❑
Blood Test	❑	❑	❑	❑
Chest X-ray	❑	❑	❑	❑
Spinal X-ray	❑	❑	❑	❑
Dental X-ray	❑	❑	❑	❑
Urine Test	❑	❑	❑	❑

HABITS:

	None	Light	Moderate	Heavy
Smoking	❑	❑	❑	❑
Smoked how long?_____				
Coffee	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Salt	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

Check the following conditions you have had before, or have now:

- ❑ Allergies
- ❑ Alcoholism
- ❑ Anemia
- ❑ Cholesterol High
- ❑ Constipation
- ❑ Cancer
- ❑ Cold Sores
- ❑ Cold Hands/Feet
- ❑ Chronic Cough
- ❑ Diabetes
- ❑ Lung Problems
- ❑ Prostate
- ❑ Diarrhea (frequent)
- ❑ Dry Skin
- ❑ Epilepsy
- ❑ Eczema
- ❑ Cystic Breasts/Ovary
- ❑ Gall Bladder
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Malaria
- ❑ Liver Problems
- ❑ Hysterectomy
- ❑ Tire Easily
- ❑ Menstrual Cramps
- ❑ Irregular Periods
- ❑ Frequent Muscle Cramps
- ❑ Miscarriage
- ❑ Nosebleeds
- ❑ Joints Stiff
- ❑ Joints Ache
- ❑ Multiple Sclerosis
- ❑ Rheumatic Fever
- ❑ Bladder Problems
- ❑ Weak Fingernails
- ❑ Other_____
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Feet Swollen
- ❑ Poor Appetite
- ❑ Varicose Veins
- ❑ Perspire Very Little
- ❑ Frequent Sore Throats
- ❑ Kidney Stones
- ❑ Headaches
- ❑ Colon

Family History: List any past/present health problems:

Father _____

Mother _____

Spouse _____

Brother _____

Sister _____

Children _____