Safe Harbor
Chiropractic, PC

PLEASE PRINT

How were you referred to Safe Harbor Chiropractic? _____

Name: _____ Date: _____
First Middle Last

Address: _____ City: _____ Zip: _____

Phone Home:_____ Work: _____ Cell: _____

Email: _____

Sex: _____ Female _____Male Birth date: _____ Age: _____

Occupation: _____ Employer: _____

Level of Education Completed _____

Marital Status ____Single ____Married ____Separated ____Divorced ____Partner ____Widowed

Is your present condition due to an injury? ____Yes ____No ____On the job ____Auto ____Other

Has the accident been reported: ____Yes ____No ____To Employer ____ Auto Carrier

Have you received chiropractic treatment previously? _____Yes _____No
If yes, explain: _____
Were you pleased with your chiropractic care? ____Yes ____No

Reason for seeking care: What are your symptoms?

_____
_____

When did this problem begin? _____
Have you had anything like this before? _____
Is it getting better, worse or no change? _____
List any doctors seen for this: _____
List any diagnosis and treatment/outcomes: _____
_____
List medications taking for this condition: _____
How long have you had this health concern? _____

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Health History

Current medications, reason and length of time:

_____

Current vitamins/supplements, reason and length of time, are they prescribed, are you getting results?

_____

Check only those conditions which are applicable:

___AIDS/HIV	___Cataracts	___Hepatitis	___Osteoporosis	___Suicide Attempt
___Alcoholism	___Chemical Dependency	___Hernia	___Pacemaker	___Thyroid Problems
___Allergy Shots	___Chicken Pox	___Herniated Disc	___Parkinson's Ds	___Tonsillitis
___Anemia	___Depression	___Herpes	___Pinched Nerve	___Tuberculosis
___Anorexia	___Diabetes	___High Cholesterol	___Pneumonia	___Tumors
___Appendicitis	___Emphysema	___Kidney Disease	___Polio	___Lyme's disease
___Arthritis	___Epilepsy	___Liver Disease	___Prostate Problems	___Ulcers
___Bleeding disorders	___Glaucoma	___Headaches	___Psychiatric Care	___Fractures
___Vaginal infections	___Breast lump	___Goiter	___Miscarriage	___Venereal Disease
___Bronchitis	___Gout	___Multiple Sclerosis	___Cancer	___Heart Problems
___Stroke	___Metabolic Disorder	___Neck Pain	___Low back pain	___Migraines
___Arm/back tingling	___Shoulder pain	___Hand pain/tingling	___Leg pain/tingling	___Jaw pain
___Lung problems	___Blood pressure issues	___Ankle swelling	___Cold hands/feet	___Blurred vision
___Difficulty breathing	___Stuffy nose	___Allergies	___Fainting	___Weight loss
___Poor appetite	___Excessive appetite	___Nervousness	___Confusion	___Dental problems
___Excessive thirst	___Frequent nausea	___Vomiting	___Painful urination	___Bladder trouble
___Discolored urine	___Gas/bloating	___Heartburn	___Colitis	___Irritable bowel
___Black stools	___Bloody stools	___Constipation	___Hemorrhoids	___Fatigue
___Tired after 2pm	___Wake up b/t 1&3 am	___Loss of sleep	___Difficulty hearing	___Ear pain
___Excessive urination	___Eczema			

Have you had any surgeries? If yes, please describe: _____

_____

Women only:
Date of last menstrual period: _____
Do you have the following occur with your periods: ___ Painful cramping ___Heavy ____Long lasting
___Migraines ___Clotting ___Fatigue ____Leg weakness _____Bowel habit changes
Any abnormal PAP or mammograms? _____ Yes _____No
If so, please explain: _____

Do you have hot flashes?	____Yes	____No
Do you have night sweats?	____Yes	____No
Do you have insomnia?	____Yes	____No
Do you have memory loss?	____Yes	____No
Do you have mood swings?	____Yes	____No
Do you have low sex drive?	____Yes	____No
Do you have fatigue?	____Yes	____No
Do you have breast tenderness?	____Yes	____No
Do you have Weight gain?	____Yes	____No
Do you have anxiety?	____Yes	____No

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Men only:

Do you have decreased urinary flow? ____Yes _____No
Do you have abdominal weight gain? _____ Yes _____No
Do you have elevated cholesterol? ____Yes _____No
Do you have erectile dysfunction? ____Yes _____No
Do you have depression/anxiety? ____Yes _____No
Do you have fatigue? _____ Yes _____No
Do you have a loss of muscle tone? ____Yes _____No
Do you have irritability? ____Yes _____No
Difficulty concentrating? ____Yes _____No
Date of last prostate exam: _____ Any abnormalities? If so, please explain: _____

Family Health History:

___Diabetes	___Osteopenia	___Thyroid Problems	___Cancer
___Alcoholism	___Osteoarthritis	___Lung Disease	___Autoimmune Disorders
___Mental Illness	___Kidney Disease	___High Blood Pressure	___Digestive Disorders
___Depression	___Eye Disorders	___High Cholesterol	___Osteoporosis
___Arthritis	___Liver Disease	___Liver Disease	___Addictions

___Other _____

I hereby certify the information provided on these pages to be accurate to the best of my knowledge.

Patient Name _____

Patient Signature _____ Date _____