



Please Fill In Completely.

Print Name _____ Email _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Please Check Sex Male Female Left handed Right handed Married Single

Health History:

Give reason for seeking chiropractic care: _____

Describe any health problems, including how long you've had them: _____

Are you under the care of any other doctor? Yes No

If Yes, the conditions being treated for: _____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes No If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? Yes No Who? _____

Wellness Commitment

At our office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please select your personal level of commitment toward obtaining and maintaining health and wellness.

10% ---- 20% ---- 30% ---- 40% ---- 50% ---- 60% ---- 70% ---- 80% ---- 90% ---- 100%

Where did you hear about our clinic?
or who referred you? _____

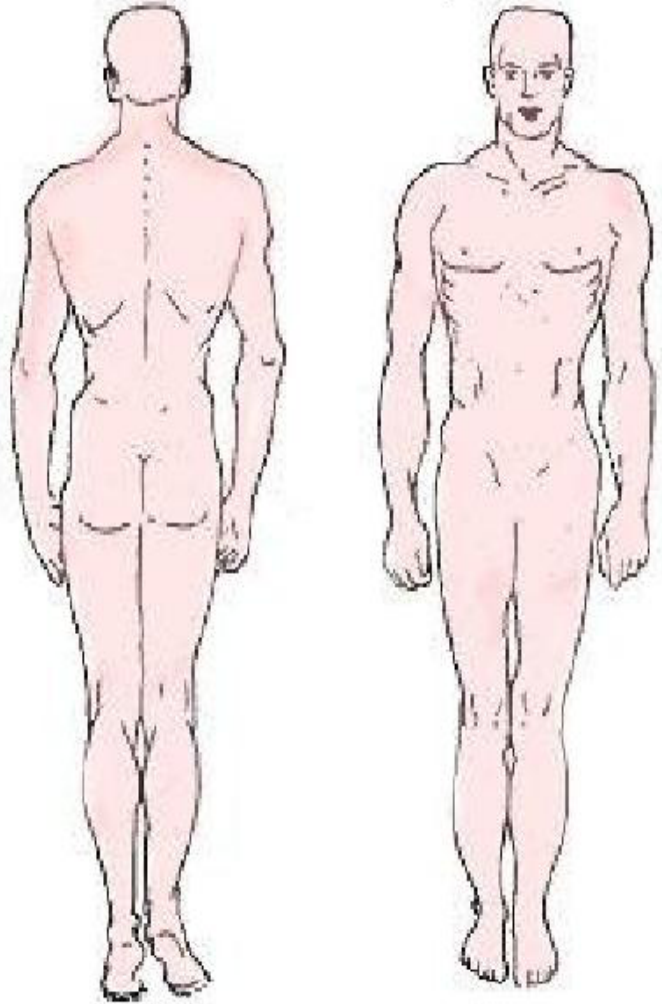
FEMALES: Please check one is there a possibility of you being pregnant? Yes No

Please Fill In Below

If u had the following, or if you suffer from the following, Please Check ✓

Constantly or Frequently	Constantly or Frequently	Some times Or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female roblems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestiveproble	<input type="checkbox"/>	<input type="checkbox"/>
UrinaryProblem	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Circle the areas where you have any problems.
Please also describe these problems.



**Below, Please Fill In Any Other Health information
You Feel We Might Need For Your Care.**

Thank you for being complete and thorough
Your Signature Below Please

Date: _____

Gwynedd Chiropractic

631 South Sumneytown Pike, North Wales, PA 19454

215-661-8600