* Patient Information

adjust CHIROPRACTIC

Patient Name:
Last Name: _____
First Name: _____

Sex: □ Male □ Female □ Other_____
Age: _____
Birthdate: _____

Marital Status (Check one):
□ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered for _____ year

Whom may we thank for referring you?
_____

Date: _____
SS/HIC/Patient ID: _____

Occupation: _____
Patient Employer/School: _____
Employer/School Address: _____
Employer/School Phone: _____

Spouse's Info:

Name: _____
Phone: _____
Birthdate: _____
Employer: _____

↘ Address/Contact Info

Street: _____
City: _____
State: _____
Zip: _____

E-mail: _____

Phone Numbers
Main Phone: _____
Work/other Phone: _____
Best time and place to reach you:
_____ _____

In Case of Emergency, Contact

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____

Is this condition due to an accident? □ Yes □ No Date:_____

Type of accident: □ Auto □ Work □ Home □ Other:_____

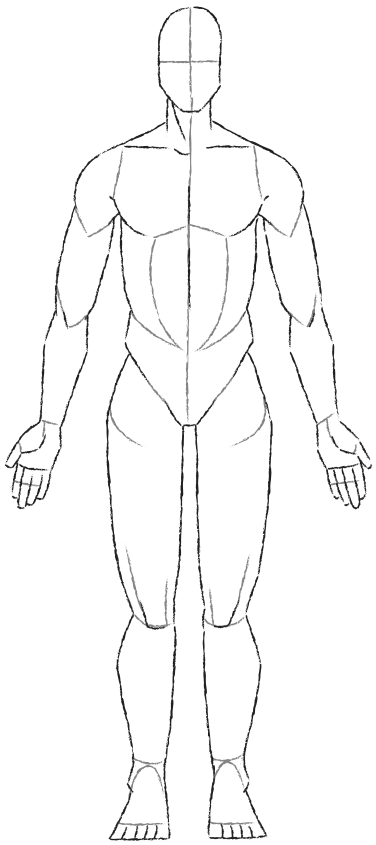
To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Workers Comp □ Other

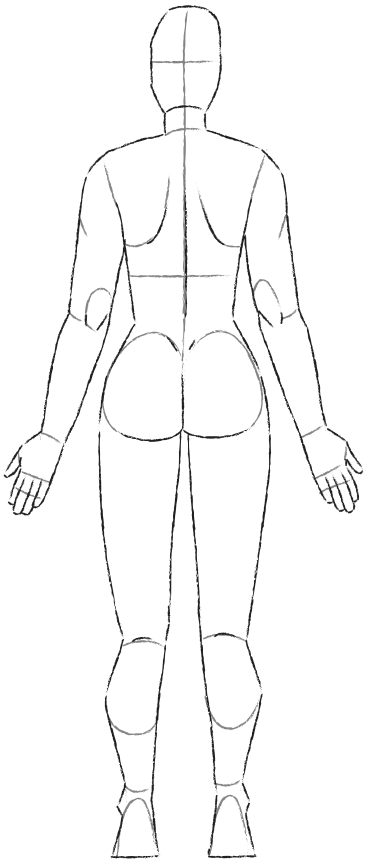
Attorney name (if applicable)_____

Patient Condition

Reason for visit:_____

- When did your symptoms appear?
  _____
- Is it getting progressively worse?□ Yes □ No □ Unknown_____
- Mark X's on the picture where you have pain, numbness, or tingling. ->
- Rate the severity on a Scale of 1-10 (with 10 as severe)_____
- Type of Pain? □ Dull □ Sharp □ Throbbing □ Numbness □ Aching □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other_____
- How often does this pain occur_____
- Constant or Come and go?
  _____
- Diffuculty with: □ Sleep □ Work □ Daily routine □ Recreation





Condition (check all that apply)	**Yes**	**No**	**Condition** (check all that apply)	**Yes**	**No**
AIDS/HIV	□	□	Liver Disease	□	□
Alcoholism	□	□	Measles	□	□
Allergy Shots	□	□	Migraine Headaches	□	□
Anemia	□	□	Miscarriage	□	□
Anorexia	□	□	Mononucleosis	□	□
Appendicitis	□	□	Multiple Sclerosis	□	□
Arthritis	□	□	Mumps	□	□
Asthma	□	□	Osteoporosis	□	□
Bleeding Disorders	□	□	Pacemaker	□	□
Breast Lump	□	□	Parkinson's Disease	□	□
Bronchitis	□	□	Pinched Nerve	□	□
Bulimia	□	□	Pneumonia	□	□
Cancer	□	□	Polio	□	□
Cataracts	□	□	Prostate Problem	□	□
Chemical Dependency	□	□	Psoriasis	□	□
Chicken Pox	□	□	Psychiatric Care	□	□
Diabetes	□	□	Rheumatoid Arthritis	□	□
Emphysema	□	□	Rheumatic Fever	□	□
Epilepsy	□	□	Scarlet Fever	□	□
Fractures	□	□	Stroke	□	□
Glaucoma	□	□	Suicide Attempt	□	□
Goiter	□	□	Thyroid Problems	□	□
Gonorrhea	□	□	Tonsillitis	□	□
Gout	□	□	Tuberculosis	□	□
Heart Disease	□	□	OTHER		

*Health History

adjust CHIROPRACTIC

Previous Treatment for Your Condition (Check all that apply):

□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other:

Name and Address of Other Doctor(s) Who Have Treated You for Your Condition: _____

_____

Date of Last:

- Physical Exam: _____Spinal X-Ray: _____Blood Test: _____Spinal Exam: _____Chest X-Ray: _____Urine Test: _____

- MRI, CT-Scan, Bone Scan, Ultrasound: _____ Other test:_____

Habits

Exercise (Check one):

□ None □ Moderate □ Daily □ Heavy

Daily Work or Activity level(Check one):

□ Sitting □ Standing □ Light Labor □ Heavy Labor

Smoking: _____ Packs/Day

Alcohol: _____ Drinks/Week

Coffee/Caffeine Drinks: _____ Cups/Day

High Stress Level: Reason: _____

Are you pregnant? □ Yes □ No □ Possibly Due Date: _____ _____

Medications	**Allergies**
Any other health info you would like us to know?	Signature:_____Date:_____