Date: _____

Patient name:_____ Date of Birth: _____

Address: _____

Drivers License #/State: _____

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____

Phone number (Cell) _____ (Home) _____

Email:_____ Spouses Name: _____

Who may we thank for referring you? _____

Emergency Contact: _____ Phone # _____

Reason for visit: _____

Is this due to an accident? _____

☐ Auto ☐ Work related ☐ Home

If so, has it been reported to: ☐ Insurance company ☐ Employer ☐ Work Comp

When did the symptoms appear? _____

Is the condition getting worse?

_____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Recreation ☐ Daily routine

Are the following painful or difficult? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Bending

☐ Lifting ☐ Other _____

Where do you feel the pain:

Rate your pain 1-10 _____

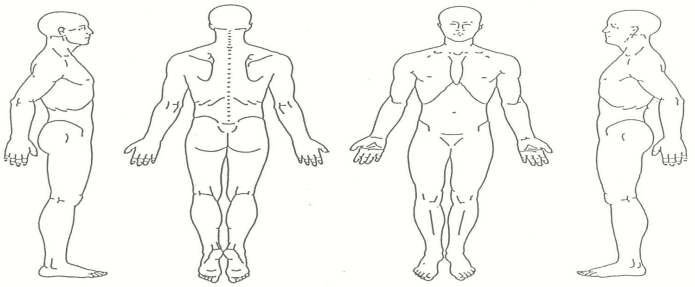
Do you feel the following:

☐ Numbness ☐ Tingling ☐ Weakness

☐ Sharp ☐ Throbbing ☐ Dull

☐ Burning ☐ Swelling ☐ Ache

☐ Stiffness ☐ Cramps



How does your condition make you feel? _____

What would you be able to do/enjoy that you can't currently if this condition was gone?

_____

Have you been treated for this condition previously? ☐ Yes ☐ No

☐ Medication ☐ Surgery ☐ Chiropractic ☐ Nutrition ☐ Acupuncture ☐ _____

Date of last exam: Physical _____ Blood work _____ Urine _____

X-Rays_____ MRI/CT/Ultrasound _____

Have you had or have any on the following:

AIDS	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Allergy shots	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Anorexia	☐ Yes ☐ No	Appendicitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Autoimmune	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	↑ Blood pressure	☐ Yes ☐ No	Breast lump	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Bulimia	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Chemical	☐ Yes ☐ No	Chicken pox	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Dependency		Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Goiter	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Mononucleosis	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Pinched nerve	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Prostate problem	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Prosthesis	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Rheumatoid	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Arthritis		Suicide attempt	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Typhoid fever	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Vaginal	☐ Yes ☐ No
Venereal disease	☐ Yes ☐ No	Whooping cough	☐ Yes ☐ No	infections	

Other: _____

Do you get headaches? ☐ Yes ☐ No How often _____

How would you describe them?

☐ Migraine ☐ Visual disturbance ☐ Nausea ☐ Tension ☐ Vomiting ☐ Related to allergies

☐ Aura ☐ Light sensitive ☐ Related to allergies ☐ Ocular migraine

Are you pregnant? ☐ Yes ☐ No Due Date_____

Have you ever take antibiotics? ☐ Yes ☐ When_____

Are you taking birth control ☐ Yes ☐ No

Have you used hormone replacement therapy ☐ Yes ☐ No

Are you Vegetarian ☐ Yes ☐ No Do you skip meals ☐ Yes ☐ No

How much sugar do you eat ☐ Little ☐ Moderate ☐ High Do you crave sugar ☐ Yes ☐ No

Injuries/Surgeries you have had	Description	Date
Falls		
Head injuries		
Broken Bones		
Auto Accidents		
Surgeries		