Dr Stephanus P. E. Boshoff D.C.; C.Ad; D.A.C.A.C.D., Q.N.C.P.
BOSHOFF CHIROPRACTIC CENTER

PERSONAL HISTORY

Date: _____ Name: _____ _____
First Last

Address: _____ City/State: _____ Zip: _____

Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Phone: _____ _____ Email: _____
Home or Cell Work

Circle One: Single Married Divorced Widowed

Emergency Contact: _____ _____ _____
Name Phone Number Relation

Whom May we Thank for referring you: _____
Are you / have you been disabled from work? _____
Current medications or Natural Remedies: _____
_____

CURRENT HEALTH CONDITION:

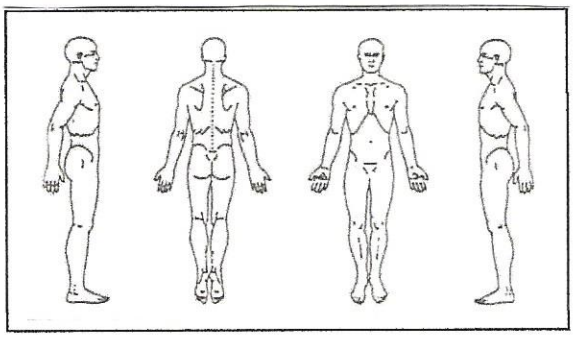
Please fill out this section for the complaint you feel is most significant.
Then indicate on the drawing where your pain is located.

Major Complaint: _____ Date of Onset: _____ sudden gradual
How bad is your pain or ache? **Please circle:** no pain 1 2 3 4 5 6 7 8 9 10 Unbearable

Describe your pain or complaint: Dull Deep Tingling Sharp Superficial Burning Ache
Spasm Stabbing Numbness Other_____
Does the pain radiate to other parts of the body? YES NO Where_____
Frequency: Occasional Intermittent Constant
How long does the pain last? _____
What makes the pain worse? Standing Walking Cold
Sitting Lifting Bending Sleeping Sex Twisting
Heat Other _____
What makes the pain better?
Sitting Standing Rest Heat Cold Medication

Have you had any other treatment for this condition?

_____



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