

Name (Las	st, First, M.I.):		□ M □ F	DOB:	
Marital st	t atus: - Single - Partnered - Marri	ied			
Address:		City:		State: Zip	:
E-mail Address:					
Contact #	# :				
Employer	·		Occupation	<u> </u>	
	cy Contact:	#:	Relationship:		
	of Children		Ages:	•	
	we thank for referring				
	our office: uld you like to gain from Chiroprac	tic care? Pacolya evicting condit	ion 🗆 W	ellness Both	
riiat wo	and you like to gain from Cimoprae	tic care: Resolve existing conditi		billiess - bout -	
		HISTORY OF COMPLAIN	NT		
Mhat hro	wight you in				
wiiat bio today?	ought you in				
	result of an				
auto acci When did	dent? I this problem				
egin?					
How did t happen?	the injury				
What reli	eves your	What mak	es vour svmi	otoms worse?	
symptom Do vou fe	pel it: (circle all				
hat apply		On or off during the day/ week	Worst	in Morning/ Mid-day/ Evening	
Please ma	ark and label where you are feeling you	ır complaint:			
R= Ra	adiating B= Burning D=Dull A=Aching			\bigcirc \bigcirc	
N=N::	mbness S= Sharp/Stabbing T=Tingling			77 73	
				1) 21 1541	
Chiro	opractic History:		1		
Have y	you ever been adjusted? Yes No		1)	(1+1/2/(1X) /2	
			U		
How Id	ong were you under care?)-1-(}-1)-1	
Previo	us Chiropractor?			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
				30 77	
Was v	our family under care? Yes No				
On a scale	e of 0-10, 10 being the worst pain you	have ever experienced, what w	ould you rate	your complaint?	
Diaht nove	: 0-1-2-3-4-5-6-7-8-9-	10			
	0-1-2-3-4-5-6-7-8-9-10				
At Best: 0	-1-2-3-4-5-6-7-8-9-10				
At worst: (0-1-2-3-4-5-6-7-8-9-10	0			
	LIST ANY OTHER HEALTH	CARE PROVIDER YOU HA	VE SEEN F	OR THIS COMPLAINT	
Year	Treatment/ Results		Provider		

		HEALTH I	HISTORY			
T : /A : 1 .	TYPE	HOW LONG AC	GO TREATI	MENT	BY WHO	
Injuries/Accidents Surgeries						
Childhood/ Adult diseases	5					
NV allergies (Environm	nental/Food/Medical)? I	If yes please explair	here:			
	entary roody Medicary:	ii yes, piease expiaii	inere.			
Please explain briefly w	hat your daily diet cons	ists of?				
	p do you get a night? _			ed? Y/N		
ist ANY medications/P	rescriptions/Supplemer	nts that you are curre	ently using:			
	FAMIL	Y HISTORY- MAR	K"X" TO ALL THAT	APPLIES		
	GRANDMOTHER	GRANDFATHER	MOTHER F	ATHER	BROTHER	SISTER
CANCER						
STROKE						
HEART CONDITION AUTOIMMUNE						
DISORDER						
	conditions the docto		of? If yes, please	explain he	ere:	
	conditions the docto		of? If yes, please	explain he	ere:	
Anything else you wo	ould like the Doctor to	o know? SE MARK P= PAST,	C=CURRENT, N=		ere:	
nything else you wo	ould like the Doctor to	o know? SE MARK P= PAST,	C=CURRENT, N=I	NEVER	pnvulsions/Epilepsy	
Check if you have, or have	PLEAS e had, any symptoms in the	SE MARK P= PAST, e following areas to a si Double vision/Blu	C=CURRENT, N=Ignificant degree.	NEVER	onvulsions/Epilepsy	
Check if you have, or have Depression Headache/Migraine	PLEAS e had, any symptoms in the	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglin	C=CURRENT, N=I gnificant degree. Irred vision ng in arms, hands, finge	NEVER Coers - Di	onvulsions/Epilepsy abetes	
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache,	PLEAS e had, any symptoms in the	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglin	c=current, N=I gnificant degree. Irred vision ng in arms, hands, fingeng in legs, feet, toes	NEVER Coers Die Ri	onvulsions/Epilepsy	
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache	PLEAS e had, any symptoms in the	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglin Numbness/Tinglin	C=CURRENT, N=I gnificant degree. Irred vision ng in arms, hands, fingen ng in legs, feet, toes uent bloating	NEVER Coers Di Ri	onvulsions/Epilepsy abetes neumatoid Arthritis	
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache, ear/ hearing loss	PLEAS had, any symptoms in the	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglin Numbness/Tinglin Constipation/freq	gnificant degree. Irred vision Ing in arms, hands, fingular Ing in legs, feet, toes Ing in legs, feet, toes Ing in legs, feet, toes	NEVER Coers Die Rie Er	onvulsions/Epilepsy abetes neumatoid Arthritis nergy level	
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache, ear/ hearing loss Gall bladder/Kidne	PLEAS had, any symptoms in the	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglir Numbness/Tinglir Constipation/freq Pain with coughir	gnificant degree. Irred vision Ing in arms, hands, fingular Ing in legs, feet, toes Ing in legs, feet, toes Ing in legs, feet, toes	NEVER Coers Di Ri Coers At	onvulsions/Epilepsy abetes neumatoid Arthritis nergy level eart problem	Condition:
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache, ear/ hearing loss Gall bladder/Kidne Frequent congestion	PLEAS had, any symptoms in the	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglin Numbness/Tinglin Constipation/freq Pain with coughir Bladder/Bowel iss	c=current, N=lignificant degree. Irred vision Ing in arms, hands, finger Ing in legs, feet, toes Ing in legs, feet, toes Ing ing/Sneezing Ing/Sneez	NEVER Coers Die Rie Er	onvulsions/Epilepsy labetes neumatoid Arthritis nergy level eart problem oility to sleep	Condition:
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache, ear/ hearing loss Gall bladder/Kidne Frequent congestion Allergies/Asthma	PLEAS e had, any symptoms in the e /infections/ringing in y issues on/Sinus Pressure	Double vision/Blu Double vision/Blu Numbness/Tinglir Numbness/Tinglir Constipation/freq Pain with coughir Bladder/Bowel iss Bed Wetting Acid reflux/Heartl	c=current, N=lignificant degree. Irred vision Ing in arms, hands, finger Ing in legs, feet, toes Ing in legs, feet, toes Ing ing/Sneezing Ing/Sneez	NEVER Coers Die Rie Er He	onvulsions/Epilepsy labetes neumatoid Arthritis nergy level eart problem oility to sleep	Condition:
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache, ear/ hearing loss Gall bladder/Kidne Frequent congestic Allergies/Asthma Jaw Pain Broken bone: Confidentiality Notice: Leconnect Chiropractic LLC rivacy Policy discusses diffinis notice it is available for have read the above infor hiropractic care, diagnostic	PLEAS PLEAS PLEAS Phad, any symptoms in the Infections/ringing in Infections/ringing in Infections Pressure It is committed to maintaining ferent procedures, polices, report your convenience at the formation and certify it to be to testing, and/or therapeut	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglin Constipation/freq Pain with coughir Bladder/Bowel iss Bed Wetting Acid reflux/Hearti Heavy menstrual Heavy menstrual and rights of the patier front desk. Sign below si true and correct to the fic services, in accordan	gnificant degree. gred vision ng in arms, hands, finge ng in legs, feet, toes uent bloating ng/Sneezing sues burn problem/Heavy crampi onfidentiality of our pat nt in regards to medical stating you have been of best of my knowledge ce with this state's stat	NEVER Coers Die Rie Er Die Growth Gr	abetes neumatoid Arthritis nergy level eart problem pility to sleep ther pain/discomfort/or al information. The North of this notice to react withorize this office to y authorize payment of	otice of Patient ead a full copy of l. provide me with
Check if you have, or have Depression Headache/Migraine Dizziness/vertigo Frequent ear ache, ear/ hearing loss Gall bladder/Kidne Frequent congestic Allergies/Asthma Jaw Pain Broken bone: Confidentiality Notice: econnect Chiropractic LLC rivacy Policy discusses diffinis notice it is available for have read the above infor hiropractic care, diagnosticendered to be paid directly	PLEAS PLEAS Phad, any symptoms in the Infections/ringing in Infections Pressure It is committed to maintaining ferent procedures, polices, regord your convenience at the formation and certify it to be	b know? SE MARK P= PAST, e following areas to a si Double vision/Blu Numbness/Tinglin Constipation/freq Pain with coughir Bladder/Bowel iss Bed Wetting Acid reflux/Hearti Heavy menstrual ng and protecting the count rights of the patier ront desk. Sign below si true and correct to the cic services, in accordant in a correct to the cic services, in accordant in a correct to decline reference. I choose to decline reference.	gnificant degree. gred vision ng in arms, hands, finger ng in legs, feet, toes uent bloating ng/Sneezing sues burn problem/Heavy crampi onfidentiality of our pat nt in regards to medical stating you have been of best of my knowledge ce with this state's state acceipt of my clinical sum	NEVER Coers Die Rie Er Die Hole Die Growth of the Coert	abetes neumatoid Arthritis nergy level eart problem pility to sleep ther pain/discomfort/or al information. The North of this notice to react withorize this office to y authorize payment of	otice of Patient ead a full copy of l. provide me with for services