Date of last menstrual period_____

Health History

Please check all of the following that you currently suffering with:

□	Headache	□	Migraines	□	Frequent Nausea	□	Constipation
□	Neck Pain	□	Dental Problems	□	Irritable Bowel	□	Fatigue
□	Middle Back Pain	□	Jaw Pain	□	Excessive Thirst	□	Bloody Stools
□	Lower Back Pain	□	Vision Problems	□	Vomitting	□	Hemorrhoids
□	Shoulder Pain	□	Difficulty Breathing	□	Prostate Problems	□	Liver Problems
□	Arm Pain or Tingling	□	Stuffy Nose	□	Breast Pain or Lump	□	Stroke
□	Hand Pain	□	Allergies	□	Cramps	□	Paralysis
□	Leg Pain or Tingling	□	Fainting	□	Painful Urination	□	Tingling
□	Foot Pain or Tingling	□	Weight Loss or Gain	□	Bladder Problems	□	Numbness
□	Chest Pain	□	Poor Appetite	□	Excessive Urination	□	Cold Extremities
□	Infectious or Contagious disease	□	Auto or Work Injury	□	Head Injuries	□	Fights
□	Falls or Accidents	□	Dislocations	□	Spinal Tap	□	Surgery
□	Broken Bones	□	Use a Walker or Cane	□	Extensive Dental Work	□	Excessive Alcohol use
□	Sports Injuries		Knocked Unconscious	□	Diabetes	□	Smoking
OTHER:							

Please list any Surgeries you have had:_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

Do you know what spinal nerve stress/subluxation is? □ no □ yes If yes, please describe _____

_____

What would you like to gain from chiropractic care? _____

_____

Do you have friends/relatives who see chiropractors? □ no □ yes

If yes, do they use chiropractic for: □ health maintenance/optimization □ health problems □ both

Are you seeking chiropractic for: □ health maintenance/optimization □ health problems □ both