

DATE

PERSONAL HISTORY

Name: Address: City: State: Zip/Postal Code: Home Phone: Birth Date: Age: Sex: E-mail Address: Would you like to receive a text message reminder? Social Security #: Driver's License #: Social Insurance #: Circle One: Married / Single / Widowed / Divorced / Separated Business Employer: Type of Work: Business Phone: Spouse Social Security #: Spouse Social Insurance #: Spouse Employer: Business Phone: Type of Work: Name and Ages of Children: Referred To This Office By: Name and Number of Emergency Contact: Relationship: Who Is Responsible For Your Bill, You and Spouse Workers Comp. Auto Insurance Medicare Medicaid

CURRENT HEALTH CONDITION

Unwanted Health Condition: Other Doctors Seen For This Condition: Yes No Who? Type of Treatment: Results: When Did This Condition Begin? Has This Condition Occurred Before? Yes No Is Condition: Job Related Auto Accident Home Injury Fall Other: Date of Accident: Time of Accident: Have You Made A Report of Your Accident To Your Employer: Yes No Do You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin Other: Do You Wear A Shoe Lift? Yes No Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?

PAST HEALTH HISTORY

Please Check and Describe: Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones Other: Major Accident or Falls: Hospitalization (Other Than Above): Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit:

Below is a list of diseases which may be unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- | | |
|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Black/Bloody Stool |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Colitis |

- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolor Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

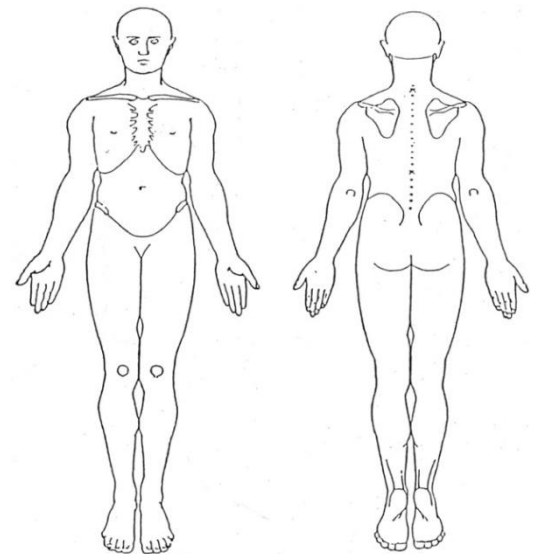
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problems as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature