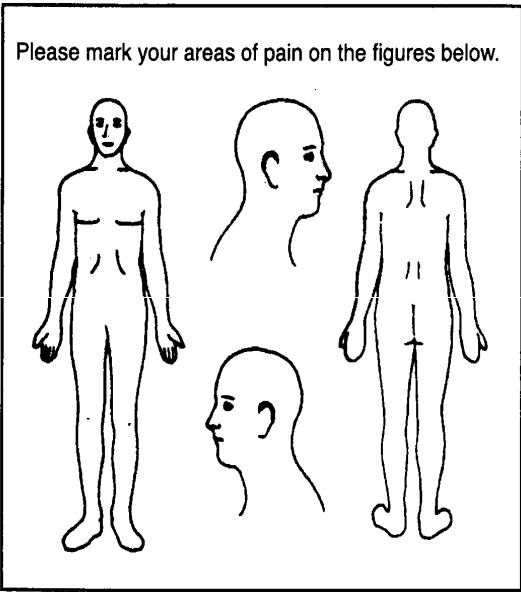


LAST NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 OCCUPATION _____
 EMPLOYER _____
 # OF CHILDREN _____ PHONE _____ CELL _____

FIRST NAME _____ PREFERRED _____
 SS# _____ BIRTHDATE _____ AGE _____
 EMAIL _____
 SPOUSE _____
 SPOUSE'S OCCUPATION _____
 REFERRED BY _____

MY GOAL FOR CONSULTING WITH THE DOCTOR: Temporary Relief Lasting Correction Let Doctor Recommend The Best Type of Care

What is your major complaint? _____
 Timing 0-25% 26-50% 51-75% 76-100% of the time
 What caused it? How did it start? (Gradual/Injury) _____
 Was it related to a work or auto accident? _____
 When was the first time you became aware of this problem? How long have you had it? _____
 Constant Comes and Goes _____ Is it progressively getting worse? Yes No
 Medications you are on now: _____
 What makes it better? _____ Worse? _____
 Describe the problem when it is at its worst? (Check all that apply) Dull Achy Sharp Shooting Refers into my arms
 Refers into my legs Other _____
 What activity would you like to be able to do again that is difficult or that **YOU CANNOT DO NOW?** _____
 This was a new/old illness. What Treatment have you had? _____



Mark any other symptoms you have had in the past 6 months.
Rate the severity of your problem: 1-10 (1—slight problem, 10—severe problem) pain.
 Leave blank if doesn't apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Numbness - Arms | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Exzema |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Numbness - Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Loss Of Feeling | <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Ear Pain / Noises | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Restricts Regular Exercise | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> High / Low |
| <input type="checkbox"/> Dificulty Speling | <input type="checkbox"/> Elbow | <input type="checkbox"/> Tiredness / Fatigue |
| <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Headaches | <input type="checkbox"/> Foot Pain |

Surgeries/Hospitalization _____ **TRAUMA FROM BIRTH TO PRESENT, PLEASE LIST BY DATE/DESCRIBE**
 Have you had an MRI/CT Scan? _____ Dates _____ 1) Injuries or Falls _____
 Previous Chiropractic Care _____ 2) Broken Bones _____
 Date of last adjustment _____ 3) Car/Bike Accidents _____
 Female: Are you pregnant at this time? Yes No Due Date _____ Do you have any metal in your body? Yes No
 Do you have a pacemaker? Yes No If yes, where? _____
 Primary care physician: _____ Phone number: _____
 Physical/Massage Therapist: _____ Phone number: _____
 Personal Trainer: _____ Phone number: _____

Signature: _____ Date: _____

Doctor's Notes:

