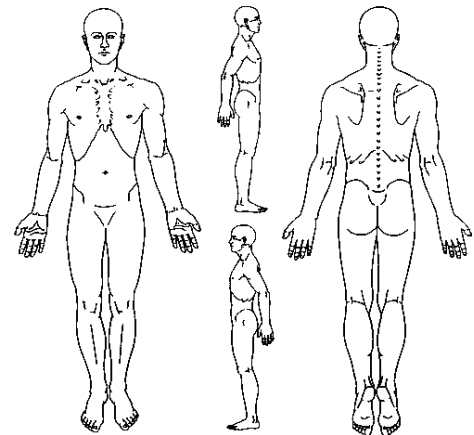


Name: _____ Referred By: _____
Address: _____ Marital Status: M S D W # of Children: _____
City, Prov, Postal Code: _____
Home Phone: (____) _____ E-mail: _____
Office Phone: (____) _____ Occupation: _____
Cell Phone: (____) _____ Employer: _____
Date of Birth: _____ Age: _____ Spouse's Name: _____

Under 18 years of age? Please fill out this section.

Parent/Guardian's Name: _____
Date of Birth: _____ Age: _____
Address: _____
City, Prov: _____ Postal Code: _____
Phone: (____) _____



Chief complaint or reason for today's visit? _____
How long have you had this condition? _____ Date of onset? _____ Cause? _____
Have you had this condition before? _____ If yes, when? _____
Is the condition related to: Work Auto Date of accident: _____ Have you lost days from work? _____
What doctors have you seen for this condition? _____
What did they do? _____

When was your last visit to a chiropractor? _____ Chiropractor's Name: _____
What are your health goals? _____ I'm a: Smoker Nonsmoker
What surgeries have you had? _____
List the drugs you are taking (prescription & nonprescription): _____
When was your last auto accident? _____

Have you or anyone in your IMMEDIATE family had any of the following conditions:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spine Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |

Please mark *X* for present conditions, *O* for past conditions.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back curvature | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Numb / tingle pain
(arms, hands, fingers) | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Pain w/ cough / sneeze |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Foot trouble |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Swollen / painful joints | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Numb / tingle pain
(legs, feet, toes) | <input type="checkbox"/> Frequent colds / flu | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Convulsions / epilepsy | <input type="checkbox"/> Difficulty bending or
with household duties | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart problem |
| <input type="checkbox"/> Difficulty standing,
Walking or sitting | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Jaw pain, TMJ, RL | <input type="checkbox"/> Menstrual problem |
| <input type="checkbox"/> Difficulty with daily activities | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Difficulty exercising | <input type="checkbox"/> Irritable | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Impotence / sexual dysfunction | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Fractured bones | <input type="checkbox"/> Tremors | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Auto accidents | <input type="checkbox"/> Allergies | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Other accidents / falls | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea / constipation |
| <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Menopausal problems |
| <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Ear infection | <input type="checkbox"/> AIDS / HIV |
| | <input type="checkbox"/> Hepatitis (A,B,C) | <input type="checkbox"/> PMS | <input type="checkbox"/> Skin problems |
| | <input type="checkbox"/> ADD / ADHD | | |

Circle all that apply to your chief complaint (please list your chief complaint). _____

Location	Onset	What makes it worse?	Type of pain?	Pain radiating? Into:	Severity of pain: <small>10 Being Worst</small>	How much out of a week?
Left	Today	Everything	Aching	Left Head	1	10%
Right	This Week	Nothing	Burning	Right Shoulder	2	20%
Both	This Month	Lifting	Deep	Front Arm	3	30%
Front	This Year	Working	Dull	Back Hand	4	40%
Back		Sitting	Numbing	Ribs	5	50%
		Bending	Sharp	Buttocks	6	60%
		Standing	Soreness	Hip	7	70%
		Sneezing	Stabbing	Leg	8	80%
	Coughing	Stiffness	Foot	9	90%	
		Tenderness		10	100%	
		Tingling				