



Chiropractic is the science, philosophy and art that utilizes the *inherent recuperative powers* of the body to *heal itself* without the use of drugs or surgery.

Welcome to our office. Help us get to know you.

Name:		Preferred Name:	
Address:		City	State Zip
Date of Birth:	Email Address:		
Phone Number:		Home or Cell	
How would you like to receive complimentary appointment reminders? TEXT EMAIL CALL None Needed			
If text is requested, what company do you use as your cell phone carrier?			
Occupation:		Employer:	
How do you spend most of your work day? Sitting Walking Standing Laboring Other			
Relationship status: Married Separated Divorced Widowed Engaged Single Other			
Name of Emergency Contact:		Phone Number:	
Relationship to you:			

Lifestyle Habits:

Please circle all that apply & specify amounts:	Drink Coffee _____	Drink Soda _____	Tobacco Use _____
	Drink Tea _____	Use Artificial Sweeteners _____	
	Drink Alcohol _____	Recreational Drugs _____	
How much water do you drink/day?		What do you do for exercise?	
		How Often: Daily _____ x Weekly	
		I don't exercise regularly	
How would you describe your diet? Poor Fair Adequate Good Excellent			
Are you on a special diet? (Paleo Vegetarian Dairy Free...)			# Fruits & Vegetables/Day
Have you recently been vaccinated? YES NO If yes, for what?			

Medications (include over the counter)	For what condition	Taken how long
Vitamins /Supplements/ Herbs		

Healthcare History

Healthcare practitioners you have seen in the last year			
Name	City	Last Visit	Reason for your visit

List ALL Surgeries/Hospitalizations		
Type	Date	Recovery outcome?

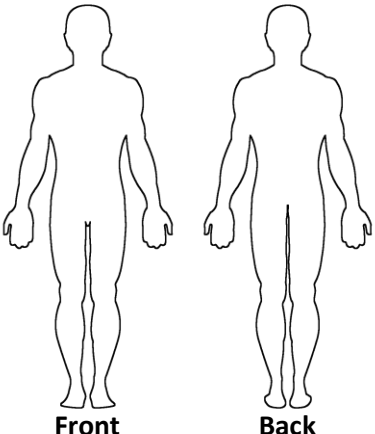
Below is a list of symptoms. Please check if you have had or are currently suffering from any of the following:

Past	Symptom	Present
	neck pain	
	headaches	
	shoulder pain	
	breathing troubles	
	cold extremities	
	allergies	
	weight loss/gain	
	confusion	
	blood sugar issues	
	prostate problems	
	cycle irregularities	
	discolored urine	
	irritable bowel	
	liver problems	
	paralysis	
	fatigue	
	cancer	
	trouble walking	

Past	Symptom	Present
	low back pain	
	arm/hand tingling	
	leg pain	
	abnormal BP	
	blurred vision	
	poor appetite	
	fainting	
	depression	
	nausea	
	breast pain/lump	
	painful urination	
	heartburn	
	bloody stools	
	leg/foot numbness	
	loss of sleep	
	ear pain	
	leg cramps	
	substance abuse	

Past	Symptom	Present
	migraines	
	jaw pain/clicking	
	heart problems	
	ankle swelling	
	sinus issues	
	excessive appetite	
	uncontrolled anxiety	
	excessive thirst	
	vomiting	
	menstrual cramps	
	frequent urination	
	gas/bloating	
	constipation	
	stroke	
	mid back pain	
	hearing loss	
	hip pain	
	hemorrhoids	

CURRENT CONDITION

Reason for your visit today? Wellness/Maintenance OTHER Specify:	
How long has this bothered you? _____ Days _____ Months _____ Years	
Have you ever seen a chiropractor before? YES NO	How long ago? If yes, was it for this condition? YES NO
Have you seen anyone else for this? YES NO	Who?
Was the outcome helpful? YES NO UNSURE	When was your last visit?
What else have you done for this?	
What makes your situation better?	What make your situation worse?
On a scale of 0-10 (0=no pain 10= most pain) How would you rate your pain?	
Please mark the diagram with the location(s) of your health concern: Is there anything else we should know?	
 <p style="text-align: center;">Front Back</p>	