Date_____ (Please Print) ID # _____

Patient Information

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Sex: ☐ M ☐ F Age: _____ DOB: _____

Soc. Sec. #: _____ Circle: Married Single Widowed Divorced Seperated

Business Employer: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Soc. Sec. #: _____

Email Address: _____ Fax #: _____

Referred To This Office By: _____

Name and Number of Emergency Contact: _____Relationship: _____

Who Is Responsible For Your Bill, You and: ☐ Spouse ☐Worker's Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Other:_____

☐ Personal Health Insurance (Name): _____ Health Card #: _____

Current Health Condition

Purpose of This Appointment: _____

Other Doctor Seen For Condition: ☐ Yes ☐ No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has It 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

Drugs 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

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other: _____

Major Accidents or Falls: _____

_____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ☐ None

☐ Doctor's Name & Approximate Date of Last Visit: _____

Primary Insurance

Insured Persons Name: _____

Relation To Patient:_____ Birthdate: _____ Soc. Sec. #: _____

Address (if different from patient): _____Phone: _____

City: _____ State: _____ Zip: _____

Insured Person Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ ID #: _____

Phone #: _____ Group #: _____ Subscriber #: _____

Name of other dependents covered under this plan: _____

Additional Insurance

Is patient covered by additional insurance? (If yes, complete information below) ☐ Yes ☐ No

Subscriber Name: _____ Relation to patient: _____ Birthdate: _____

Address (if different from patients): _____ Phone: _____

City: _____ State: _____ Zip: _____

Subscriber Employed By: _____ Business Phone: _____

Insurance Company: _____ Soc. Sec. #: _____

Contact #: _____ Group #: _____ Subscriber #: _____

Name of other dependents covered under this plan: _____

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

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- □ Pneumonia
- □ Rheumatic Fever
- □ Polio
- □ Tuberculosis
- □ Whooping Cough
- □ Anemia
- □ Measles
- □ Mumps
- □ Small Pox
- □ Chicken Pox
- □ Diabetes
- □ Cancer
- □ Heart Disease
- □ Thyroid
- □ Influenza
- □ Pleurisy
- □ Arthritis
- □ Epilepsy
- □ Mental Disorder
- □ Lumbago
- □ Eczema

INTAKE
- □ Coffee
- □ Tea
- □ Alcohol
- □ Cigarettes
- □ White Sugar

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

MUSCULO-SKELETAL CODE
- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ 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
- □ Gas/Bloating After Meals
- □ Heartburn
- □ Black/Bloody Stool
- □ Colitis

GENITO-URINARY CODE
- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored 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

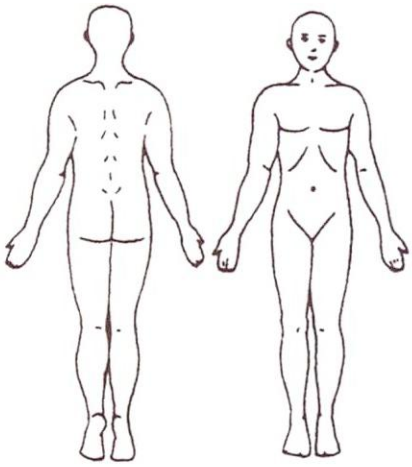
MALE/FEMALE CODE
- □ Menstrual Irregularity
- □ Menstrual Cramping
- □ Vaginal Pain/Infections
- □ Breast Pain/Lumps
- □ Prostate/Sexual Dysfunction

OTHER
- □ AIDS
- □ Hepatitis
- □ ADD/ADHD

FEMALES ONLY:
When was your last period?

_____

Are you Pregnant?
□ Yes □ No □ Not Sure



Please outline on the diagram the area of your discomfort.

_____
Patient's Signature