

DATE

I.D. NO.

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
 Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
 Check One:  Married  Single  Widowed  Divorced  Separated  
 Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_  
 Spouse's 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  
 Personal Health Insurance (Name) \_\_\_\_\_  Health Card # \_\_\_\_\_  
 Insured Person's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**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  
 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**

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 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 care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

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

**INTAKE**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive?  Yes  No

**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

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_

Are you pregnant?

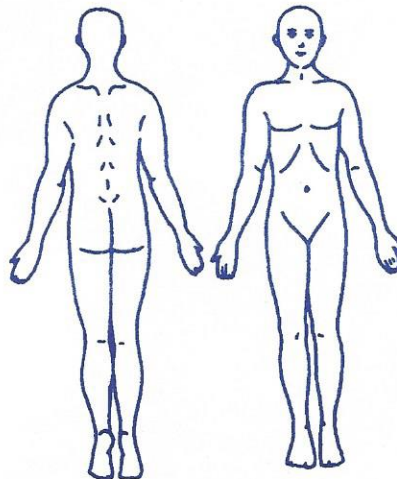
- Yes  No  Not Sure

**NERVOUS SYSTEM CODE**

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

**C-V-R CODE**

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



Please outline on the diagram the area of your discomfort

**GENERAL CODE**

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

**EENT CODE**

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

**GASTRO-INTESTINAL CODE**

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

**MALE/FEMALE CODE**

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

**FAMILY HISTORY**

The following members have a same or similar problem 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 \_\_\_\_\_