

Welcome to our office! If you need any assistance, just ask. It is our pleasure to help you.

Name: First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M W D Spouse Name: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Name(s) & Age(s) of Children: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

What are your health objectives in consulting our office? \_\_\_\_\_

Have you ever received Chiropractic care? Yes / No If yes, for what reason? \_\_\_\_\_

If you have a symptom or complaint you are seeking Chiropractic care for, please describe in detail: \_\_\_\_\_

a.) How long have you had this condition? \_\_\_\_\_ c.) Is it getting better or worse? \_\_\_\_\_

b.) Have you had this condition before? Y / N d.) If yes, when? \_\_\_\_\_

Any immediate family with similar problems? \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

Have you had any surgeries? Yes / No Please list: \_\_\_\_\_

Please choose the type of health care you are seeking:

\_\_\_\_\_ I want to be healthier five years from now than I am today.

\_\_\_\_\_ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health

\_\_\_\_\_ I have a specific concern and require help with this concern.

Please circle all symptoms you have ever had, current or previous.

Headaches	Dizziness	Fatigue	Sleeping Problems	Diarrhea	Mood Swings
Loss of Smell	Depression	Stiff Neck	Sensitive Eyes	Constipation	Menstrual Pain
Back Pain	Loss of taste	Irritability	Problem Urinating	Neck pain	Nervousness
Cold Feet	Hot Flashes	Heartburn	Upset Stomach	Loss of Balance	Numbness in Toes
Cold Hands	Ears Ringing	Ears Buzzing	Fevers	Pins and Needles in Arms	Ulcers
Cold Sweats	Fainting	Tension	Menstrual Irregularity	Pins and Needles in Legs	Numbness in Fingers

On a scale of 1-10 describe your stress level: (1=None/10=Extreme) Occupational: \_\_\_\_\_ Personal: \_\_\_\_\_

On a scale of 1-10 describe your: (1=Poor/10=Excellent)

Exercise: \_\_\_\_\_ Sleep: \_\_\_\_\_ Diet: \_\_\_\_\_ Emotional Health: \_\_\_\_\_ General Health: \_\_\_\_\_

Women only: Are you pregnant? Y / N Trying to conceive? Y / N Nursing? Y / N Taking birth control pills? Y / N

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

