

DATE

I.D. NO.

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
 Social Security # \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
 Social Insurance # \_\_\_\_\_ Circle One: Married Single Widowed Divorced Separated  
 Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Spouse's Social Insurance # \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Type of Work \_\_\_\_\_ Names 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 # \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Purpose of This Appointment \_\_\_\_\_  
 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 chiropractic care.

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

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

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

**GENITO-URINARY CODE**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**FEMALES ONLY:**

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

Are you pregnant?

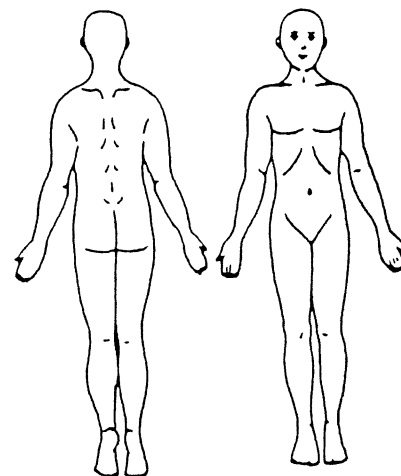
- Yes  No  Not Sure

**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**

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted:  Yes  No  Referred

\_\_\_\_\_  
Doctor's Signature