



Date _____ Social Security No. _____

Name _____ Married _____ Single _____
(last) (first) (middle)

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____ Home Phone _____

Date of Birth _____ Age _____ Number of Children _____
(month) (day) (year)

Name of Spouse _____ Health _____

Name of Children _____ Health _____

Occupation _____ Employed By _____ Business Phone _____

Primary Care Physician (PCP) _____ Phone # _____

Briefly Describe Complaint _____

Current Medications _____

Past Surgeries _____

Referred by _____

Have you had chiropractic before? _____ Where? _____

What health insurance company do you have? _____ Do you have an HSA, HRÅ or FSA? If yes, please circle.

DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING? IF YES, MARK "X)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies* | <input type="checkbox"/> Headaches* | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menstrual Cramps and Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cluster Headaches | <input type="checkbox"/> Mid Back Pain* | <input type="checkbox"/> Herniated Disc |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Shooting Head Pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Bulging Disc |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Throbbing Head Pain | <input type="checkbox"/> Pain in Shoulder Blades | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Knots in the Back Muscle | <input type="checkbox"/> Pain into Legs |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Neck Pain* | <input type="checkbox"/> Stiff Mid Back | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Base of Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pain into feet |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Head Feels Heavy | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Sciatic Pain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Clicking or Grinding in Neck | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Post-Menopausal | <input type="checkbox"/> Muscle Spasms in Neck | <input type="checkbox"/> Lower Mid Back Pain | <input type="checkbox"/> Trouble Bending |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Intestinal Gas |
| <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Shoulder Tightness | <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Pain into Buttock |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Tingling in Fingers | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Wrist Pain* |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Numbness of Arm or Hand | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Elbow Pain |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Pins and Needles in Arms or Back | <input type="checkbox"/> Low Back Pain* | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Cool Hands | | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Ear Infections | | <input type="checkbox"/> Ankle Pain |