ABOUT YOU		
First Name N	liddle Name	
Last Name		
Street Address		
Address Line 2		
City State _	Zip	
Mobile Phone Work Phone	Home Phone	
Email Address		
Date of Birth / /	Gender □ Male □ Female	
Height' V	Veight lbs	
Marital Status ☐ Single ☐ Married ☐ Separated ☐	□ Divorced □ Widowed □ Other	
Number of Children S	pouse's Name	
EMERGENCY CONTACT INFORMATION		
Name		
Phone	Relation to You	

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REFERRAL INFORMATION		
Referring Physician	Contact Info	
Referring Patient	-	
Are You Working with an Attorney?	□ Yes □ No	
How Did You Hear About Us? □ Word of Mouth □ Advertisement □ Social Media	□ Direct Marketing □ Internet	

REASON FOR VISIT		
What is the date of your scheduled appointment?	/	
How long have you had this complaint?	□ Less than 5 days (Acute) □ Between 5-30 days (Sub Acute) □ More than 30 days (Chronic)	
What caused this condition?		
What is the date this condition began? (Skip if due to accident)	/	
What terms describe your discomfort best? (aching, burning, tingling, etc.)		
On the body diagrams to the right, ple indicate your areas of symptoms by d the appropriate symbols. P - pain N - numbness W - weakness S - shooting A - aching		
On a scale of 1 to 10, with 10 being th discomfort?	e most severe, how would you rate your current level of	
None 0 1 2 3	Unbearable 5 6 7 8 9 10	
How often do you feel this discomfort	? □ Constant □ Frequent □ Occasional □ Intermittent	
How has this complaint changed sinc the onset?	^e □ Worsened □ Remained the same □ Improved	
What activity is most significantly affected by this discomfort? (Explain)		
What treatment have you received for this condition up to now?	r	

Page 4 out of 8 What aggravates this condition?	
What improves this condition or give you relief?	s
Have other health care provider(s) performed tests related to this condition?	
Have you ever had any previous episodes of this condition?	
	CURRENT HEALTH
Other than the information already	provided, do you have additional health concerns involving any of the following?
Muscles, Bones, or Joints	□ No □ Yes Explain:
Nerves, Headaches, Dizziness, or Emotional	□ No □ Yes Explain:
Head, Eyes, Ears, Nose or Throat	□ No □ Yes Explain:
Heart, Blood Pressure, or Circulation	□ No □ Yes Explain:
Shortness of Breath, Coughing, Asthma or Lung Condition	□ No □ Yes Explain:
Stomach, Bowels or Digestive Conditions	□ No □ Yes Explain:
Genital, Bladder, or Urinary Conditions	s⊓No ⊓Yes Explain:
Diabetes, Thyroid or Glandular Conditions	□ No □ Yes Explain:
Skin or Bleeding Conditions	□ No □ Yes Explain:
Allergies or Sensitivities	□ No □ Yes Explain:

PERSONA	AL AND FAMILY HISTORY
Have you had any surgical procedures?	□ No □ Yes Explain:
Are there any past illnesses or conditions we should be aware of?	□ No □ Yes Explain:
Do you have a past history of accidents or trauma?	□ No □ Yes Explain:
Are there any past illnesses or conditions we should be aware of?	□ No □ Yes Explain:
Are you presently taking any medication?	□ No □ Yes Explain:
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?	□ No □ Yes Explain:
WORK	AND SOCIAL HABITS
Current work habits: select all that apply	□ Permanently fully disabled □ Permanently partially disabled □ Cannot work due to current condition □ Full-time (20-40+ hours/week) □ Part-time (1-19 hours/week) □ Retired □ Student □ Homemaker □ Unemployed
Personal social habits: select all that apply	☐ Smoke or use tobacco products ☐ Drink alcohol ☐ Drink caffeine ☐ Use recreational drugs ☐ Other, to be discussed with doctor
Present exercise habits: select all that apply	 □ No current exercises □ Exercise daily □ Exercise 3+ times per week □ Cannot return to exercise due to current condition
Diet and nutrition habits: select all that apply	□ Vegan or vegetarian □ Daily supplements

□ Other

ADULT MEN'S HEALTH		
Do you have pain or a lump in your scrotum or testicles?	□ Yes □ No	
Do you have an impaired libido (sex drive)?	□ Yes □ No	
Do you have discharge from your penis?	□ Yes □ No	
Do you have prostate issues?	□ Yes □ No	
When was your last prostate exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a prostate exam ☐ Prefers not to answer or don't know	
When was your most recent PSA (Prostate-Specific Antigen) blood test?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PSA blood test ☐ Prefers not to answer or don't know	
What was your PSA (Prostate-Specific Antigen) level on your latest test?	☐ Normal or low ☐ Moderate ☐ High ☐ Never had a PSA level done ☐ Prefers not to answer or don't know	

ADULT WOMEN'S HEALTH		
Are you pregnant?	□ Yes □ No	
Are you nursing?	□ Yes □ No	
Are you taking birth control?	□ Yes □ No	
Do you experience painful periods?	□ Yes □ No	
Do you have irregular cycles?	□ Yes □ No	
Do you have breast implants?	□ Yes □ No	
Do you perform a regular self-breast examination?	□ Yes □ No	
Do you take Hormone Replacement Therapy?	□ Yes □ No	
Do you take oral contraceptives?	□ Yes □ No	
When was your last PAP/pelvic exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP or pelvic exam ☐ Prefers not to answer or don't know	
When was your last mammogram?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram exam ☐ Prefers not to answer or don't know	
What was the date of your last menstrual period? (only answer if still menstruating)	☐ Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ Postmenopausal ☐ Have not yet begun menstruation ☐ Prefers not to answer or don't know	

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature:	Date: _	/	_ /