Patient Information

Your Name	**Today's Date:**	**DOB:**	
Name you would like to called		**S.S.#**	
Street	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Age**	
Email Address			
Marital Status ❑M ❑D ❑W ❑S			
Emergency Contact:	**Name**	**Phone#**	
How did you hear about me / who referred you.			
Describe what you primarily want me to help you with.			

Are you under the care of any other health professional for any reason? ❑Yes ❑No

If yes please explain.

Is this your first experience with chiropractic? ❑Yes ❑No

How do you feel about chiropractic?

How long has it been since you felt good?

What kinds of treatments have you tried?

What were the results of the treatment(s).

Have you been diagnosed with a specific problem?

Is condition getting better, worse or the same since it began?

Have you ever had similar condition in the past? ❑Yes ❑No How often?

Is there anything you are unwilling to change to get well?

What do you think has prevented you from getting well in the past?

Please list here what has helped you in the past; what has helped in the past but no longer works and what if anything has made you worse.

What do you believe is a reasonable time frame to resolve this complaint you are asking for help with today?

Accidents or Injuries *(describe, location, date/time occurred)*

General

Occupation

Stress Factors ❑physical ❑psychological ❑chemical

Do you follow a regular exercise program? ❑Yes ❑No

Sleep ❑Excellent ❑Fair ❑Poor

Appetite ❑Excellent ❑Fair ❑Poor

Bowels Move __/ Day/Wk

Any gas bloating or discomfort after eating. ❑Yes ❑No

❑Excellent ❑Fair ❑Poor

Would you say your digestion is ❑Excellent ❑Fair ❑Poor

Water—glasses per day

Coffee—cups per day

Alcohol per day

Tobacco per day

Soda Drinks per day

Black Tea—cups per day

Sugar—per day

Recreational Drugs ❑Yes ❑No

Type

Quantity

Do you have a certain craving for foods or tastes? ❑Yes ❑No

Explain if yes

Do you crave food, drink or environments that are ❑hot or ❑cold? ❑Yes ❑No

Emotions:

Would others say you are mostly ❑Happy ❑Easily Irritable ❑Angry ❑Depressed ❑Worried ❑Fearful

Please list all **medications** taken & reason (prescription, vitamin, herbal)

Current Conditions

**Please put a check next to any conditions you have experienced within the last 3 months.

Sleep ❑no complaints ❑hard to fall asleep ❑night urination__/ night ❑Wake during night

Energy ❑no complaints ❑low ❑low after eating ❑high ❑up and down ❑high in the afternoon

Body Temperature ❑no complaints ❑warm natured ❑cold natured ❑cold hands and feet ❑sweat easily ❑night sweats ❑feel warmer late afternoon and night ❑flushed face ❑warm palms

Head ❑no complaints ❑headaches ❑poor memory ❑dizziness

Eyes	❑no complaints ❑corrective lenses ❑color blindness ❑eye pain ❑cataracts ❑excessive tearing ❑eye dryness
Nose	❑no complaints ❑nasal discharge mucous ❑bleeding ❑loss of smell ❑stuffy nose ❑sinusitis
Ears	❑no complaints ❑discharges ❑pain ❑poor hearing ❑ringing
Mouth Throat	❑no complaints ❑gum/teeth problems ❑difficulty swallowing ❑dry ❑frequent colds ❑TMJ ❑root canals or major dental work
Skin and Hair	❑no complaints ❑dry ❑oily ❑dandruff ❑falling out ❑early grey ❑rashes ❑itching ❑hives ❑pimples ❑ulcerations ❑bruise easily
Muscles and Bones	❑no complaints pain in: ❑neck ❑upper back ❑lower back ❑elbow ❑hands ❑knees ❑foot/ankle ❑muscular pains ❑muscle weakness
Lung	❑no complaints ❑asthma ❑trouble breathing ❑coughing with phlegm ❑dry cough ❑chest pain ❑tightness in chest ❑wheezing ❑shortness of breath
Heart	❑no complaints ❑high blood pressure ❑low blood pressure ❑palpitations ❑varicose veins ❑bleed easily ❑chest discomfort ❑ankle swelling
Digestion System	❑no complaints ❑vomiting ❑belching ❑indigestion ❑distention of abdomen after eating ❑problems with fatty or oily foods ❑constipation ❑diarrhea/loose stools ❑gas
Psychological	❑no complaints ❑bad temper ❑loss of control/violence potential ❑depression ❑treated for emotional problems in the past ❑ever considered suicide or attempted suicide ❑easily susceptible to stress

Females Only

Do you use birth control? ❑Yes ❑No	What type?	How long?
Painful or tender breasts? ❑Yes ❑No	Do you have beast implants? ❑Yes ❑No	
Ever been raped or sexually molested? ❑Yes ❑No	❑Premature Births ❑Miscarriages	Abortions? ❑No
❑Irregular ❑light ❑heavy menstrual flow? ❑No Post-menapause	Painful Menses? ❑Yes ❑No	