PERSONAL HISTORY

Name:_____ Address:_____
City: _____ State:_____ Zip Code:_____
Home Phone:_____ Work Phone:_____ DOB:_____
Cell Phone:_____ E-Mail Address:_____
Name & Number of Emergency Contact_____

CURRENT HEALTH CONDITION

Purpose of this appointment:_____
When did this condition begin?_____ Has it occurred before?__Yes __No

***Does this cause you to be:**	***How does this affect your work:**	***How does this affect your life:**
O Moody	O Decision Making	O Lose Patience with Family
O Irritable	O Decreased Productivity	O Restricts Household Duties
O Interrupt Sleep	O Exhausted at End of Day	O Hinders Exercise/Sports Activities
O Restricted on Daily Activities	O Unable to Work Long Hours	O Interferes with Hobbies & Activities

Other Doctors Seen For This Condition:_____
Type of Treatment: _____ Results:_____
Diagnostic Tests/Date Performed: O Xray_____ O MRI_____ O EMG_____

Drugs You Now Take:
O Pain Killers O Muscle Relaxers O Anti-inflammatories O Blood Pressure Meds O Diabetes Meds
O Cholesterol Meds O Anxiety Meds O Depression Meds O Blood ThinnerMeds O Hormones
List other drugs:

List the hours per week participating in repetitive stress activities:

O Work_____ O Sports _____ O Recreation_____ O Exercise_____ O Computer_____ O Driving ____

PAST HEALTH & TRAUMA HISTORY

List dates and descriptions of previous surgeries:

O Appendectomy O Tonsillectomy O Gall Bladder O Hernia O Back Surgery O Hysterectomy O Other:

List dates and descriptions of previous injuries:
Auto:_____
Sport:_____
Slip/Fall:_____
Childhood:_____

List previous sport & recreational activities you have participated in:_____

Previous Chiropractic Care: O None O Doctor's Name & Date of Last Visit_____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

__Pneumonia
__Rheumatic Fever
__Polio
__Tuberculosis
__Whooping Cough
__Anemia
__Measles
__Mumps
__Small Pox
__Chicken Pox
__Diabetes
__Cancer
__Heart Disease
__Thyroid
__Influenza
__Pleurisy
__Arthritis
__Epilepsy
__Mental Disorders
__Lumbago
__Eczema
__Fibromyalgia
__Lupus
__Scleroderma
__Rheumatoid Arthritis
__Gout
__Multiple Sclerosis
__HIV/AIDS

INTAKE
__Coffee
__Tea
__Alcohol
__Cigarettes
__White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL SYSTEM
__General Stiffness
__Clicking Jaw
__Neck Pain
__Arm Pain
__Hand Pain
__Shoulder Tension
__Pain Between Shoulders
__Mid Back Pain
__Low Back Pain
__Leg Pain
__Shoulder Pain
__Elbow Pain
__Wrist/Hand Pain
__Hip Pain
__Knee Pain
__Ankle Pain
__Foot Pain

NERVOUS SYSTEM
__Anxiety
__Headaches
__Nervous
__Irritability
__Stress
__Tension
__Fatigue
__Loss of Sleep
__Cold Extremities
__Tingling Extremities
__Numb Extremities
__Paralysis
__Depression
__Confusion
__Memory Loss
__Dizziness
__Fainting
__Convulsions
__Fever

EENT
__Vision Problems
__Dental Problems
__Ear Aches
__Hearing Difficulty
__Allergies
__Stuffed Nose
__Sore Throat

C-V-R
__Heart Problems
__Chest Pain
__Blood Pressure Problems
__Irregular Heart Beat
__Shortness of Breath
__Lung Problems
__Varicose Veins
__Ankle Swelling
__Stroke

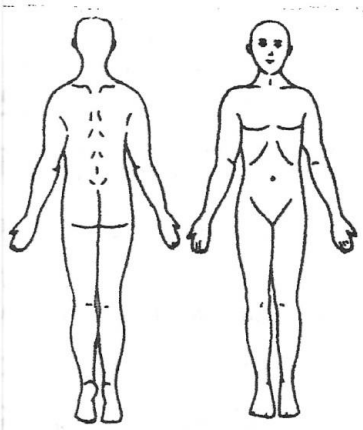
GASTRO-INTESTINAL
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Liver Problems
__Gallbladder Problems
__Weight Trouble
__Abdominal Cramps
__Gas/Bloating After Meals
__Heartburn
__Black/Bloody Stool
__Colitis

GENITO-URINARY
__Kidney Problems
__Bladder Problems
__Painful/Excessive Urination
__Discolored Urine

MALE/FEMALE
__Menstrual Cramps
__Menstrual Irregularity
__Vaginal Pain/Infection
__Breast Pain/Lumps
__Prostate Problems
__Erectile Dysfunction
__Other

FEMALES ONLY:
Date of last period?_____
Are you pregnant?_____

Please outline on the diagram below the area of your discomfort.



FAMILY HISTORY
The following members have a same or similar problem as I do:
__ Mother
__ Father
__ Brother
__ Sister
__ Spouse
__ Child

AUTHORIZATION FOR TREATMENT
I hereby authorize the doctor to treat my condition as he deems appropriate. I also understand and agree that I am responsible for all bills incurred in this office resulting from professional services provided to me.

PATIENT'S SIGNATURE_____**DATE**_____
PARENTAL CONSENT TO TREAT A MINOR_____**DATE**_____