PATIENT INFORMATION

Date: .... SSN: .... Birthday: ....

First Name: .... Middle Name: .... Last Name: ....

Sex: ○ F ○ M Height: .... Weight: ....

Marital Status: ○ Yes ○ No Spouse Name: .... # of Children: ....

Home#: .... Cell#: .... Work#: ....

Address: ....

City: .... State: .... Zip: ....

Emergency Contact: .... Emergency Relation: .... Emergency Phone: ....

Email: ....

PATIENT SOCIAL

Alcohol:	○ Daily	○ Weekly	○ Occasion	○ Never
Diet Food Products:	○ Daily	○ Weekly	○ Occasion	○ Never
OTC Stimulants:	○ Daily	○ Weekly	○ Occasion	○ Never
Homemade Food:	○ Daily	○ Weekly	○ Occasion	○ Never
Soft Drinks:	○ Daily	○ Weekly	○ Occasion	○ Never
Water:	○ Daily	○ Weekly	○ Occasion	○ Never
Caffeine:	○ Daily	○ Weekly	○ Occasion	○ Never
Drugs:	○ Daily	○ Weekly	○ Occasion	○ Never
Exercise:	○ Daily	○ Weekly	○ Occasion	○ Never
Processed Food:	○ Daily	○ Weekly	○ Occasion	○ Never
Tobacco:	○ Daily	○ Weekly	○ Occasion	○ Never

HEALTH CHECKLIST

- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Back Pain
- ☐ Bruise Easily
- ☐ Cold Extremities
- ☐ Depression
- ☐ Dizziness
- ☐ Fatigue
- ☐ Hemorrhoids
- ☐ Irregular Heart Beat
- ☐ Kidney Stones
- ☐ Loss of Smell
- ☐ Pacemaker
- ☐ Prostate Trouble
- ☐ High Blood Pressure
- ☐ Spinal Curvatures
- ☐ Swollen Joints
- ☐ Ulcers
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Breast Lump
- ☐ Cancer
- ☐ Constipation
- ☐ Diabetes
- ☐ Excessive Menstruation
- ☐ Frequent Urination
- ☐ High Blood Pressure
- ☐ Irregular Menstrual Cycle
- ☐ Loss of Memory
- ☐ Loss of Taste
- ☐ Polio
- ☐ Sciatica
- ☐ Sinus Infection
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Varicose Veins
- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Cramps
- ☐ Digestion Problems
- ☐ Eye Pain or DIfficulties
- ☐ Headache
- ☐ Hot Flashes
- ☐ Kidney Infection
- ☐ Loss of Balance
- ☐ Nosebleeds
- ☐ Poor Posture
- ☐ Shortness of Breath
- ☐ Insomnia
- ☐ Swelling of Ankles
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other: ....

COMPLAINT INFORMATION

Injury Occurred: ○ Automobile ○ Work ○ Third-Party ○ Other Injury Date: ....

Injury Origin: ....

Desk Discomfort: ....

Frequency: ○ Always ○ Hourly ○ Daily ○ Occasionally

Interfere w/ Activities: ○ Yes ○ No Affected Sleep: ○ Yes ○ No

Missed Work: ○ Yes ○ No Unable to Work from: .... Unable to Work til: ....

Affected Appetite: ○ Yes ○ No Explain: ....

Reduced Work: ○ Yes ○ No Explain: ....

Does it Worsen: ○ Yes ○ No Explain: ....

Weather Affects It: ○ Yes ○ No Explain: ....

Aggravates Condition: ....

Improves Conditions: ....

Received Treatment: ○ Yes ○ No Explain: ....

X-rays Taken: ○ Yes ○ No Explain: ....

Same Condition Before: ○ Yes ○ No Date: .... Practitioner: ....

HISTORY

Last Physical Exam: .... Primary Phys: .... Phys Phone #: ....

Phys City: .... Phys State: .... PhysZip: ....

Health Condition: ....

Previous Chiro Care: ○ Yes ○ No Date: .... Explain: ....

Chance Pregnant: ○ Yes ○ No Planning: ○ Yes ○ No

Medications: ....

Supplements: ....

Broken Bones: ○ Yes ○ No Treatment: ○ Yes ○ No Explain: ....

Sprains/Strains: ○ Yes ○ No Treatment: ○ Yes ○ No Explain: ....

Hospitalized: ○ Yes ○ No Explain: ....

Surgery: ○ Yes ○ No Explain: ....

Auto Accident: ○ Yes ○ No Treatment: ○ Yes ○ No Explain: ....

Struck Unconscious: ○ Yes ○ No Treatment: ○ Yes ○ No Explain: ....

Eating Disorder: ○ Yes ○ No Explain: ....

Stroke: ○ Yes ○ No Explain: ....

Family Health Hist: ....