

DATE _____	I.D. NO. _____
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Email: \_\_\_\_\_

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Social Security # \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Social Insurance # \_\_\_\_\_ Circle One: Married Single Widowed Divorced Separated

Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Social Insurance # \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Type of Work \_\_\_\_\_ Name and Ages of Children \_\_\_\_\_

Referred To This Office By: \_\_\_\_\_

Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who Is Responsible For Your Bill, You and  Spouse  Workers' Comp.  Auto Insurance  Medicare  Medicaid

Personal Health Insurance (Name) \_\_\_\_\_  Health Card # \_\_\_\_\_

Insured Person's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Unwanted Health Condition \_\_\_\_\_

Other Doctors Seen For This Condition:  Yes  No \_\_\_\_\_ Who? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When Did This Condition Begin? \_\_\_\_\_ Has This Condition Occurred Before?  Yes  No

Is Condition:  Job Related  Auto Accident  Home Injury  Fall  Other: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Have You Made A Report of Your Accident To Your Employer:  Yes  No

Drugs You Now Take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine

Insulin  Other \_\_\_\_\_

Do You Wear A Shoe Lift?  Yes  No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? \_\_\_\_\_

**PAST HEALTH HISTORY**

Please Check and Describe:

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery

Broken Bones  Other \_\_\_\_\_

Major Accident or Falls: \_\_\_\_\_

Hospitalization (Other Than Above): \_\_\_\_\_

Previous Chiropractic Care:  None  Doctor's Name & Approximate Date of Last Visit \_\_\_\_\_

Below are a list of diseases which are unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           |

**INTAKE**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive?  Yes  No

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

**MUSCULO-SKELETAL CODE**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**FEMALES ONLY:**

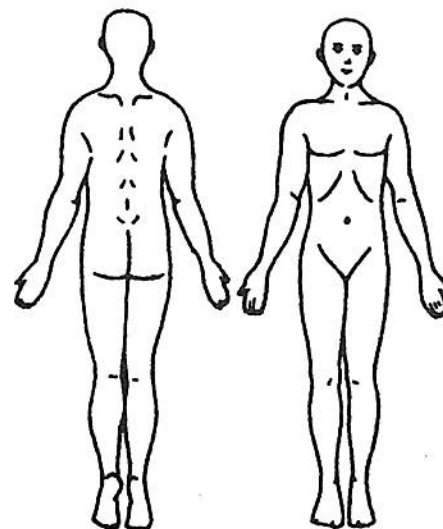
When was your last period? \_\_\_\_\_

Are you pregnant?

- Yes  No  Not Sure

**GENITO-URINARY CODE**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine



Please outline on the diagram the area of your discomfort

**NERVOUS SYSTEM CODE**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**C-V-R CODE**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**GENERAL CODE**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**EENT CODE**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**MALE/FEMALE CODE**

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FAMILY HISTORY**

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, x-rays, is for examination only and the X-ray negatives remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent to treat a Minor \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature of Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_