Last name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_ Single/Married/Divorced/Widow

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Care Information**

Name of family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_

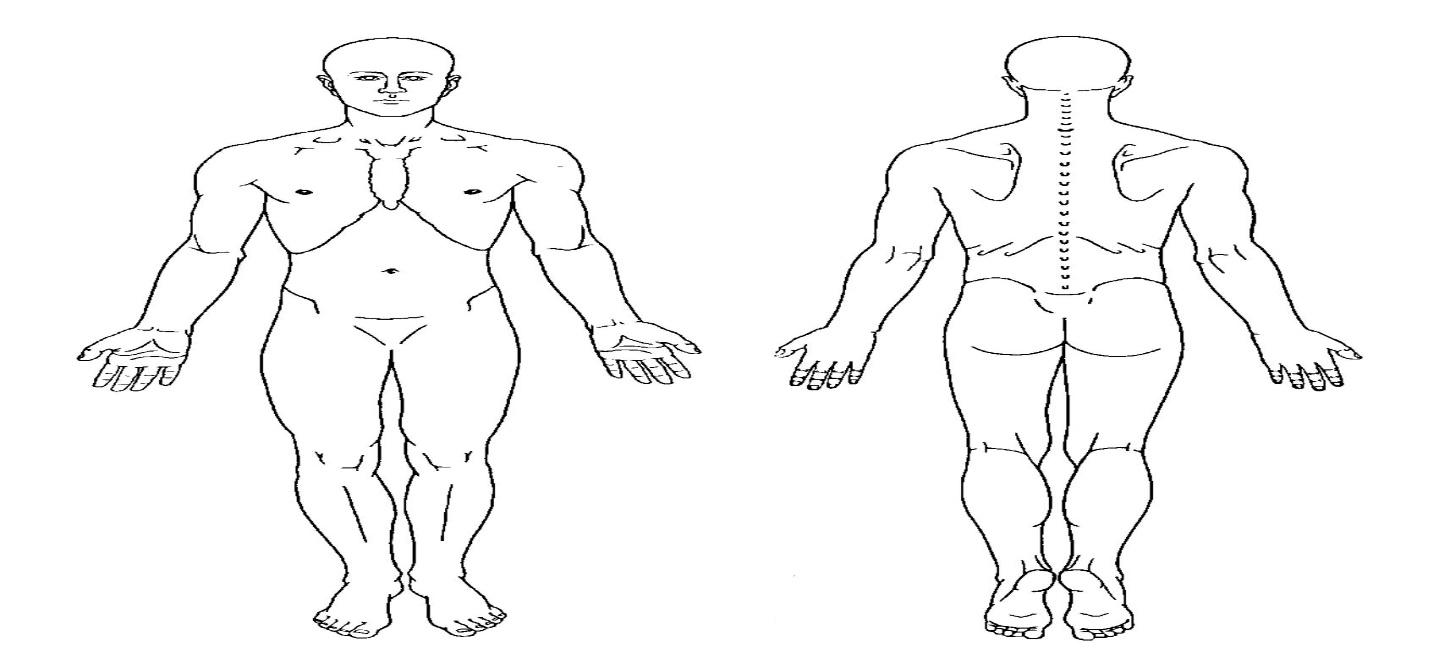
Have you been to a chiropractor: Yes/No Date of Last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Illness/Conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant: Yes/No

Please mark on the picture where you have had symptoms according to the indicated codes

 S= Stiffness A= Aching P= Pain N= Numbness T= Tingling B= Burning

Have you had any surgeries in the last 5 years: Yes/No If yes, Last Surgery Date:\_\_\_\_\_\_\_\_\_\_\_\_

Reason for surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Listed below are common symptoms. If you have ever had a listed symptom in the past or present please check that symptom in the appropriate column.**

**Past Present Past Present Past Present**

\_\_\_\_ Abnormal Heart Rate \_\_\_\_\_ \_\_\_\_ Shortness of Breath \_\_\_\_\_ \_\_\_\_\_ Skin Itching \_\_\_\_

\_\_\_\_ Swelling \_\_\_\_\_ \_\_\_\_ Cough \_\_\_\_\_ \_\_\_\_\_ Ulcer \_\_\_\_

\_\_\_\_ Poor Circulation \_\_\_\_\_ \_\_\_\_ Sinus Infections \_\_\_\_\_ \_\_\_\_\_ Heart Attack \_\_\_\_

\_\_\_\_ Low Blood Pressure \_\_\_\_\_ \_\_\_\_ Heartburn \_\_\_\_\_ \_\_\_\_\_ Stroke \_\_\_\_

\_\_\_\_ High Blood Pressure \_\_\_\_\_ \_\_\_\_ Abdominal Pain \_\_\_\_\_ \_\_\_\_\_ Bladder infection \_\_\_\_

\_\_\_\_ Low Appetite \_\_\_\_\_ \_\_\_\_ Diarrhea \_\_\_\_\_ \_\_\_\_\_ Cancer \_\_\_\_

\_\_\_\_ High Appetite \_\_\_\_\_ \_\_\_\_ Constipation \_\_\_\_\_ \_\_\_\_\_ Prostate Troubles \_\_\_\_

\_\_\_\_ Weight Loss \_\_\_\_\_ \_\_\_\_ Skin Rashes \_\_\_\_\_ \_\_\_\_\_ Breast Troubles \_\_\_\_

\_\_\_\_ Weight Gain \_\_\_\_\_ \_\_\_\_ Eczema \_\_\_\_\_ \_\_\_\_\_ HIV / AIDS \_\_\_\_

\_\_\_\_ Menstrual Cramps \_\_\_\_\_ \_\_\_\_ Painful Urination \_\_\_\_\_ \_\_\_\_\_ Depression \_\_\_\_

\_\_\_\_ Irregular Menses \_\_\_\_\_ \_\_\_\_Loss of Bladder Control\_\_\_\_\_ \_\_\_\_\_ Anxiety \_\_\_\_

\_\_\_\_ Menopause Symptoms\_\_\_\_\_ \_\_\_\_ Frequent Urination \_\_\_\_\_ \_\_\_\_\_ Insomnia \_\_\_\_

\_\_\_\_ Bed wetting \_\_\_\_\_ \_\_\_\_ Dizziness \_\_\_\_\_ \_\_\_\_\_ Ear Noises \_\_\_\_

\_\_\_\_ Headaches \_\_\_\_\_ \_\_\_\_ Hand Numbness \_\_\_\_\_ \_\_\_\_\_ Eye Pain \_\_\_\_

\_\_\_\_ Ear Pain \_\_\_\_\_ \_\_\_\_ Feet Numbness \_\_\_\_\_ \_\_\_\_\_ Fatigue \_\_\_\_

**Please mark on the line the pain level (0-10) that most accurately represents your pain:**

**Right Now \_\_\_\_\_\_\_\_\_ At Best \_\_\_\_\_\_\_\_\_ At Worst \_\_\_\_\_\_\_\_**

(Pain Scale)

**(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)**

**List any MEDICATIONS:**



**None:**

**List:**

**Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**