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:_____

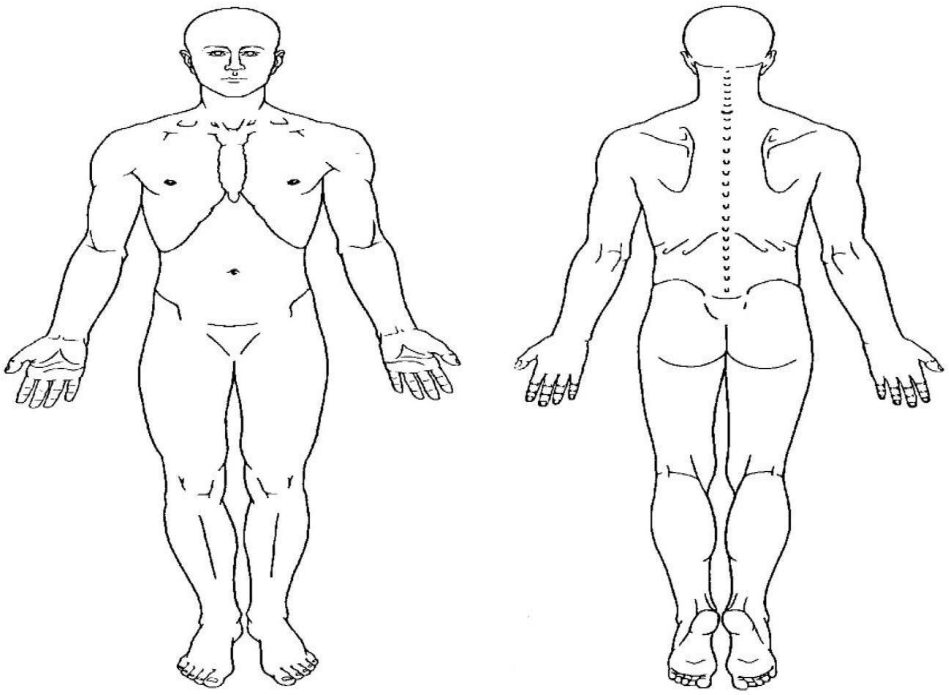
Name of Chiropractor: _____

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)