WELCOME

Date _____

Name _____ Male / Female

Address _____City_____State_____Zip_____

Home Phone _____Cell_____Work_____

Email _____

DOB _____Age_____SSN#_____- _____- _____

Employer _____

Employer's Address _____

Marital Status _____ Number of Children _____

How were you referred to our office? _____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name _____
Address _____City_____State_____Zip_____
Home Phone_____Cell_____Work_____

*** NOTICE ***

Although we are providers for many insurance carriers, we CANNOT GUARANTEE PAYMENT OR COVERAGE of chiropractic services. If you would like to know details regarding payment under your specific insurance plan, please contact your insurance provider.

Signature:_____

Date: _____

Health History Questionnaire

Current Complaints:

(1) _____How long? _____
(2) _____How long? _____
(3) _____How long? _____

Have you ever received chiropractic care ? YES / NO When? _____

Health History:

( ) Neck pain / stiffness
( ) Headaches / migraines
( ) Ear aches
( ) Ears ringing
( ) Vision problems
( ) Pain between shoulders
( ) Arm pain
( ) Chest pain
( ) Wrist pain
( ) Low back pain
( ) Constipation / irritable bowel
( ) Stomach problems / nausea
( ) Menstrual cramps irregularity
( ) Hip pain / difficulty walking
( ) Sciatica / leg pain
( ) SI Joint pain
( ) Numbness/tingling in extremities, fingers or toes
( ) Joint stiffness / tension
( ) Nervousness
( ) Fatigue / sleep problems
( ) Depression
( ) Stress
( ) Dizziness
( ) Hypertension
( ) Tendonitis / arthritis
( ) Allergies / asthma

Have you been under medical care? If so, for what condition and how long?

_____

_____

Medications? _____
Side effects? _____

Have you ever had surgery? If so, please explain the procedure performed and what year?

_____

_____

_____

Family History: Heart disease Arthritis Cancer Diabetes Other

****FEMALES****
Are you pregnant? YES / NO / MAYBE
Date of last menstrual cycle? _____

Circle words describing your condition:

constant	pinching	painful
comes / goes	shooting	knife-like
sharp	stiff	tight
dull	sore	tender
achy	weak	mild
throbbing	jolting	moderate
pounding	pressure	intense
burning	numb	severe
piercing	tingling	other _____

Circle areas of pain on figure below: