Acct # _____
(Office Use Only)

WELCOME

Date _____

Name _____ Male / Female

Mailing Address _____ Unit/Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____ Work Phone_____

Email _____

Date of Birth _____ Age_____ SSN#_____- _____- _____

Employer _____

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 ***

I agree to promptly notify my provider of any changes in my health insurance plan and/or coverage including changes to my address and/or phone number. I understand that my failure to do so will make me fully responsible for the entire bill as this is not the responsibility of the Provider. I understand that the provider will bill my insurance as a courtesy to me and I am financially responsible for all treatment charges whether the insurance company pays or not. This includes, but is not limited to, deductible, co-insurance, co-pays, non-covered services or out-of-network services.

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: