

DATE: \_\_\_\_\_

ID # \_\_\_\_\_

### PERSONAL HISTORY

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex M F  
Cell Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Email: \_\_\_\_\_ Single Married Widowed Divorced Separated  
Business Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Phone: \_\_\_\_\_ Best Phone # to Reach You: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Name/Ages of Children: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
Referred to This Office By: Person \_\_\_\_\_ Mailer Newspaper Insert Other  
Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

### 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/Auto Insurance carrier? Yes No  
Who is Your Current Primary Care Physician? \_\_\_\_\_  
When Was the Last Time You Saw Him/Her? \_\_\_\_\_ Reason: \_\_\_\_\_  
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 Other Condition Other Than 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 Accidents or Falls: \_\_\_\_\_  
\_\_\_\_\_  
Hospitalizations (Other Than Above): \_\_\_\_\_  
\_\_\_\_\_  
Previous Chiropractic Care: None Doctor's Name & Approximate date of Last Visit \_\_\_\_\_

Below is a list of diseases which may seem 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:**

- Pneumonia
- Rheumatic Fever
- Polio
- Tuberculosis
- Whooping Cough
- Anemia
- Measles
- Mumps
- Small Pox
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Thyroid
- Influenza
- Pleurisy
- Arthritis
- Epilepsy
- Mental Disorders
- Lumbago
- Eczema

**INTAKE**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN 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 Stools
- Colitis

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_  
 First day of last period? \_\_\_\_\_  
 Are you pregnant?  
 Yes  No  Unsure

**GENITO-URINARY CODE**

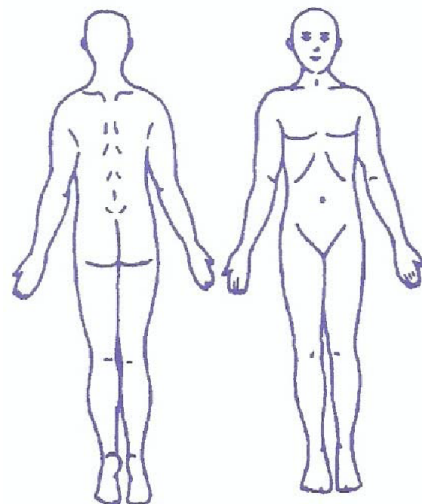
- Bladder Troubles
- Painful/Excessive Urination
- Discolored Urine

**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



Please outline on the diagram the area of your discomfort

**GENERAL CODE**

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

**EENT CODE**

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

**GASTRO-INTESTINAL CODE MALE/FEMALE CODE**

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

- 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

Doctor Name: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_