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PERSONAL HISTORY

Date: _____ Social Security #: _____ Driver's License #: _____
Name: _____ Address: _____ APT #: _____
City: _____ State: _____ Zip: _____ Email: _____ Would you like to receive our free monthly newsletter?
Home Phone: _____ Business Phone: _____ Cell Phone: _____
Birthdate: _____ Age: _____ Sex: M F Ht. _____ Wt. _____
Business/Employer: _____ Type of Work: _____
Check One: Married Single Widowed Divorced Separated No. of Children _____
Name of Emergency Contact _____ Phone No.: _____
Referred to this office by: _____
Who is responsible for your bill: Self Spouse Workman's Comp. Medicaid Medicare
 Auto Insurance Personal Health Insurance Other Medicare # _____
Method of payment for today's services: Cash Check M/C Visa AMEX Discover

HOW CAN WE SERVE YOU?

Purpose of this appointment: _____

I have no complaints. I am here for a wellness check up.

Subluxations (spinal misalignments) **Cause Dis-ease** and serious unwanted health conditions that people suffer from every day.
Subluxations will affect your health by **Reducing LIFE** to the body.

1.) What is your *first health concern*? _____ First occurrence date: _____

Subluxations irritate nerve fibers causing various sensations. Which describes yours? **Mild**
 Sharp Dull Throbbing Burning **Moderate**
 Aching Stabbing Numbness Radiating **Severe**

Depending on the type and degree of subluxation, nerve pressure can be felt at various frequencies.

How frequent is your concern? Constant Frequent On & Off Occasional Daily

2.) What is your *second health concern*? _____ First occurrence date: _____

Subluxations irritate nerve fibers causing various sensations. Which describes yours? **Mild**
 Sharp Dull Throbbing Burning **Moderate**
 Aching Stabbing Numbness Radiating **Severe**

Depending on the type and degree of subluxation, nerve pressure can be felt at various frequencies.

How frequent is your concern? Constant Frequent On & Off Occasional Daily

Taking appropriately prescribed drugs is the 3rd leading cause of death in this country. List the ones you take.

- 1.) _____ 5.) _____ 9.) _____
- 2.) _____ 6.) _____ 10.) _____
- 3.) _____ 7.) _____ 11.) _____
- 4.) _____ 8.) _____ 12.) _____

PAST HEALTH HISTORY

Please list all surgeries (with dates): _____

Major Surgery: Heart Cancer Gall Bladder Hysterectomy/Prostate Other _____

Broken Bones (Please use dates): _____

Major accidents or falls (Please use dates): _____

PLEASE CHECK ALL THAT APPLY:

NEUROLOGICAL

- Headaches
- Migraines
- Blackouts
- Irritable
- Nervousness
- Tremors
- Allergies
- Seizures
- Stress / Anxiety
- Depression
- Fatigue
- Sleeping Problems
- Unexplained Weight Loss
- Loss of Balance
- Dizziness / Vertigo

CARDIO-VASCULAR

- High Blood Pressure
- Low Blood Pressure
- Rapid Heartbeat
- Chest Pain
- Swelling of the Ankles

EYES, EARS, NOSE & THROAT

- Frequent Colds / Sinus Infections
- Hearing Loss
- Allergies
- Ear Aches
- Ringing in the Ears
- Loss of Smell / Taste
- Thyroid Trouble
- Vision Problems

DO YOU HAVE

- Cancer
- STD
- Heart Disease
- Diabetes Type I Type II

GASTRO INTESTINAL

- Diarrhea
- Constipation
- Colon Trouble
- Loss of Bowel Control
- Cramps / Bloating
- Acid Reflux
- Nausea / Vomiting

GENITO-URINARY

- Bed Wetting
- Frequent Urination
- Loss of Urine Control
- Kidney Infection
- Liver Trouble
- Ulcers
- Prostate Trouble
- Erectile Dysfunction

RESPIRATORY

- Asthma
- Chronic Cough
- Sleep Apnea
- Smoker

Females:

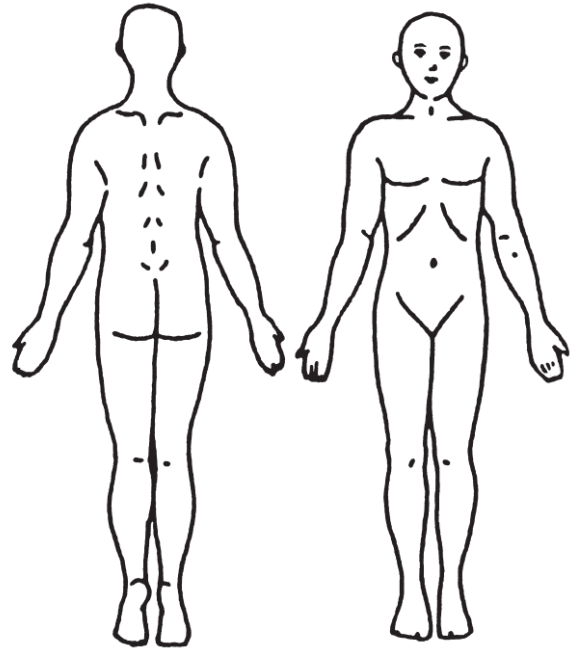
Are you pregnant?
 Yes No Maybe

When was your last period?

- Menstrual Problems
- Infertility
- Menopausal
- Perimenopausal
- Numbness / Tingling

Where _____

Please use diagram to indicate the areas of your discomfort.



YOU NEED TO KNOW

Chiropractic is NOT designed to make you Instantly Feel Better. It IS designed to make you Instantly Heal Better. The longer you've been harming yourself, the longer it takes to heal. Symptoms are the final state of Disease, Damage, Decay and Dysfunction!

Please understand that your original patient records, including x-rays, cannot be released for ANY reason. In order to obtain a digital copy of your x-rays, a 72-hour advance notice is necessary, as well as a required, pre-paid processing fee of \$20.00.

Patient's Signature: X _____ SS #: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____