



Schulte Family Chiropractic

Patient Name _____

Date of Birth _____

Today's Date _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to:

- Job Sports Auto Fall
 Home Injury Chronic Discomfort Other

Please explain _____

If job related, have you made a report of your accident to your employer? Yes No

When did this condition begin? _____

Has this condition:

- Gotten worse Stayed constant Comes and Goes

Does this condition interfere with:

- Work Sleep Daily routine Other activities

Please explain _____

Has this condition occurred before? Yes No

Please explain _____

Have you seen other doctors for this condition? Yes No

Doctor's Name(s) _____

Type(s) of treatment _____

HEALTH CONDITIONS

Please **circle** the health concern or concerns you may be experiencing now or have experienced in the recent past. Each area of concern relates to an area of the spine and nerve function. While they may seem unrelated to the purpose of this appointment, they can affect the overall evaluation, care plan and the possibility of being



C5
C6
C7
T1

Sore Throat - Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma - Allergies
High Blood Pressure
Heart Conditions

C1
C2
C3
C4

Headaches
Migraines - Dizziness
Sinus Problems
Allergies - Fatigue
Head Colds
Vision Problems
Difficulty Concentrating

T2
T3
T4
T5
T6
T7
T8
T9

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis - Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers - Gastritis
Kidney Problems

L1
L2
L3
L4
L5
S
A
C
R
A
L

Constipation - Colitis
Diarrhea - Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

Other: _____

HEALTH HABITS

- Do you smoke? Yes No
- Do you drink alcohol? Yes No
- Do you drink coffee, tea or soda? Yes No
- Do you exercise regularly? Yes No
- Do you wear: Arch Supports
 Heel lifts
 Inner Soles
 Sole lifts

FOR WOMEN

- Are you pregnant? YES NO
- Are you nursing?
- Are you taking birth control?
- Do you experience painful periods?
- Do you have irregular periods?
- Do you have breast implants?

MEDICATIONS, VITAMINS AND SUPPLEMENTS

Cholesterol medication _____ Blood pressure medicine _____

Stimulants _____ Blood thinners _____

Tranquilizers _____ Pain killers (including aspirin) _____

Muscle relaxers _____ Insulin _____

Other medications _____

Vitamins & Supplements I now take and why _____

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care** – Symptomatic relief of pain or discomfort
- Corrective care** – Correcting and relieving the cause of the problem as well as the symptom
- Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition.**

EXPERIENCE WITH CHIROPRACTIC

Who may we thank for referring you? _____

Have you been adjusted by a Chiropractor before? Yes No

Reason for those visits? _____

Doctor's name: _____

Approximate date of last visit

AWARENESS OF THE CHIROPRACTIC PRINCIPLES

Were you aware that:

- Doctors of Chiropractic work with the nervous system? **Yes** **No**
- The nervous system controls all bodily functions and systems? **Yes** **No**
- Chiropractic is the largest natural healing profession in the world? **Yes** **No**