Name _____ Occupation _____
Address _____ Marital Status S M D W
City _____ Prov ____ PC _____ Spouse's Name _____
Phone: (C) _____ (W) _____ No. of children _____
E-mail _____ Referred By_____
Date of Birth _____ (Age _____)

Chiropractic History

Have you previously seen a chiropractor? □ Yes □ No Reason _____
Did they take x-rays? □Yes □ No If yes, when was your last visit_____

Current Health Condition □ *I'm here for wellness and have no complaints (Please skip to the next section)*

Reason for today's visit _____
_____
Pain or problem started_____ Why do *you* think the problem/pain started? _____
_____
Pain is: □ Sharp □ Dull □ Constant □ Intermittent □ Feels like _____
Pain/Problem interferes with: □ Work □ Sleep □ Routine □ Other _____
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is it worse during certain times of the day? _____
Is this condition getting progressively worse? □ Yes □ No
Other Doctors seen: _____

Other symptoms:

□ Headaches
□ Neck Pain / stiff
□ Sleeping Problems
□ Back Pain
□ Nervousness
□ Tension
□ Irritability
□ Chest Pains
□ Dizziness
□ Face Flushed
□ Pins & Needles in Legs
□ Pins & Needles in Arms
□ Numbness in Fingers
□ Numbness in Toes
□ Shortness of Breath
□ Fatigue
□ Depression
□ Light Bothers Eyes
□ Double Vision
□ Loss of Memory
□ Ears Ring / buzzing
□ Fever
□ Fainting
□ Cold Sweats
□ Loss of Smell
□ Loss of Taste
□ Difficulty Swallowing
□ Diarrhea
□ Feet Cold
□ Hands Cold
□ Stomach Upset
□ Nausea
□ Constipation
□ Loss of Balance
□ Ear Infections
□ Asthma
□ Allergies
□ Frequent colds/flu
□ Menstrual problems
□ IBS / Crohn's disease
□ Anxiety
□ Multiple Sclerosis
□ Blood Clots

Other conditions, diseases, or concerns:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate dates: _____
Any work, sports or other injuries: _____
Any medications you are currently taking: _____
Have you had surgery? □ Yes □ No What type? _____
When?_____
Any significant family medical conditions/history: _____
_____
Give a brief description of the physical nature of your work or daily routine: _____
_____
Rate your occupational stress (1-10, 10 being the most stressful) _____ Rate your family / life stress (1-10) _____
Do you smoke? □ Yes □ No How many per day? _____ Do you drink alcohol? □ Yes □ No How many per week? ____

As a result of my chiropractic care, I would like to: *(Please check all that apply)*

□ Feel better quickly □ Have a healthier spine and better postural alignment
□ Improved function and performance □ Have a better quality of life

Signature _____ Date _____