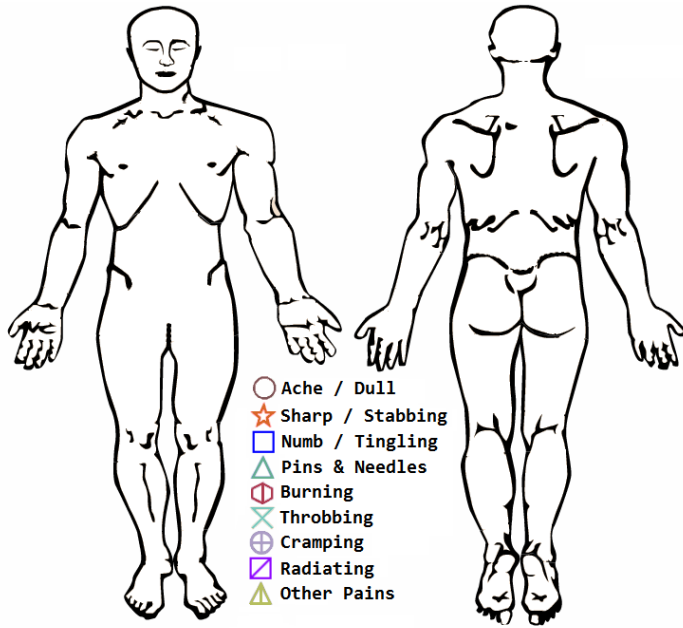


Phone:

### Patient Information:

Date	SSN	Birthday
First Name	Middle Name	Last Name
Sex Male      Female	Height	Weight
Married/Civil Union:	Spouse Name	# of Children
Home #	Cell #	Work #
Address		
City	State	Zip
Emergency Contact	Emergency Relation	Emergency Phone
Email		

### Patient Symptoms:



Ache / Dull  
 Sharp / Stabbing  
 Numb / Tingling  
 Pins & Needles  
 Burning  
 Throbbing  
 Cramping  
 Radiating  
 Other Pains

### Patient Social

Alcohol:	Daily	Weekly	Occasionally	Never	Caffeine:	Daily	Weekly	Occasionally	Never
Diet Food Products:	Daily	Weekly	Occasionally	Never	Drugs:	Daily	Weekly	Occasionally	Never
OTC Stimulants:	Daily	Weekly	Occasionally	Never	Exercise:	Daily	Weekly	Occasionally	Never
Homemade Food:	Daily	Weekly	Occasionally	Never	Processed:	Daily	Weekly	Occasionally	Never
Soft Drinks:	Daily	Weekly	Occasionally	Never	Tobacco:	Daily	Weekly	Occasionally	Never
Water:	Daily	Weekly	Occasionally	Never					

## Referral Information:

Referring Physician:		Referred Patient:		Referred by	
Advertisement:	Yes	No	Advertisement:		
Referred Directory:	Yes	No	Referred Directory:		

## Chiropractic Experience:

Who referred you to our office:						
Where did you hear about us?	Newspaper	Sign	Yellow Pages	Mailing	Community Event	Other
Have you been adjusted by a chiropractor before?	Yes	No	If yes, Why?			
		Doctor's Name:			Approximate Date of Visit	

## Employer Information:

Employed:		Employer Name			
Employer Address:					
Employer City:		Employer State:		Employer Zip:	
Occupation:		Work Supervisor:		Supervisor #:	
Work Duties:					

## Complaint Information:

Injury Occurred:	Work	Automobile	Third-Party	Other	Injury Date:	
Injury Origin:						
Desc Discomfort:						
Interfere w/ Activities:	Yes	No	Affected Sleep:	Yes	No	Frequency:
Missed Work:	Yes	No	Unable to Work from:		Unable to Work Until:	
Affected Appetite:	Yes	No	Explain:			
Reduced Work:	Yes	No	Explain:			
Does it Worsen:	Yes	No	Explain:			
Weather Affects it:	Yes	No	Explain:			
Aggravates Condition:						
Improves Condition:						
Received Treatment:	Yes	No	Explain:			
X-rays Taken:	Yes	No	Explain:			
Same Condition Before:	Yes	No	Date:		Practitioner:	

## For Women Only:

Are you pregnant?	Yes	No	Are you taking birth control?	Yes	No	Do you have irregular cycles?	Yes	No
Are you nursing?	Yes	No	Do you experience painful periods?	Yes	No	Do you have breast implants?	Yes	No

## Insurance Information:

Payment Name	Primary Phone #	Primary ID/Policy
Payment Address		
Payment City	Payment State	Payment Zip
Primary Group #	Primary Name	Primary DOB
Secondary Name	Secondary Phone #	Secondary ID/Policy
Secondary Address		
Secondary City	Secondary State	Secondary Zip
Secondary Group #	Secondary Name	Secondary DOB
Claim #	Claim Contact	Claim #
Attorney Name	Attorney Phone #	

## Personal Health History

Last Physical Exam:	Primary Phys:	Phys Phone #:
Phys City:	Phys State:	Phys Zip:
Health Conditions:		
Previous Chiro Care:	Yes No Date:	Condition(s) treated:
Chance Pregnant:	Yes No Planning: Yes No	
Medications:		
Supplements:		

## Personal Incident History:

Broken Bones:	Yes No	Treatment:	Yes No	Explain
Sprains/Strains:	Yes No	Treatment:	Yes No	Explain
Hospitalized:	Yes No	Explain:		
Surgery:	Yes No	Explain:		
Auto Accident:	Yes No	Treatment:	Yes No	Explain
Struck Unconscious:	Yes No	Treatment:	Yes No	Explain
Eating Disorder:	Yes No	Explain:		
Stroke:	Yes No	Explain:		

## Health Checklist:

Allergies	Alcoholism	Anemia
Arteriosclerosis	Arthritis	Asthma
Back Pain	Breast Lump	Bronchitis
Bruise Easily	Cancer	Chest Pain
Cold Extremities	Constipation	Cramps
Depression	Diabetes	Digestion Problems
Dizziness	Excessive Menstruation	Eye Pain or Difficulties
Fatigue	Frequent Urination	Headache
Hemorrhoids	Venereal Disease	Hot Flashes
Irregular Heart Beat	Irregular Menstrual	Kidney Infection
Kidney Stones	Loss of Memory	Loss of Balance
Loss of Smell	Loss of Taste	Nosebleeds
Pacemaker	Polio	Poor Posture
Prostate Trouble	Sciatica	Shortness of Breath
High Blood Pressure	Sinus Infection	Insomnia
Spinal Curvatures	Stroke	Swelling of Ankles
Swollen Joints	Thyroid Condition	Tuberculosis
Ulcers	Varicose Veins	

## Family Health History:

Family Health History

## EHR Information:

Pefered Language	Smoking Status	Race
Ethinicty	I choose to decline receipt of my clinical summary after every visit	
Current Medications And Dosage		
Medication Allergies		

Signature

Date: