WELCOME

ABOUT YOU

Patient Name: _____ Nickname: _____
LAST FIRST MI

Birthdate: _____ Age: _____ SS#: _____ Male Female

Mailing address: _____
CITY STATE ZIP

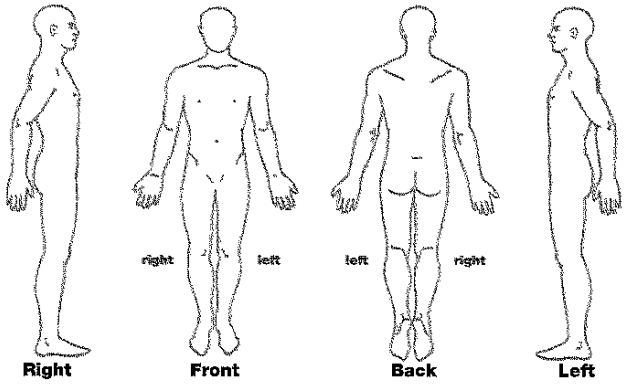
Phone: _____ Cell: _____ Referred by: _____

REASON FOR VISIT

Are you in pain? Y / N
Were you injured in school? Y / N
Were you injured playing sports? Y / N
If yes, what sports do you play? _____
Is this a new injury? Y / N
How long have you been in pain? _____
Please explain what happened: _____
_____
Is the pain getting worse? Y / N
Has this ever happened to you in the past? Y / N
If yes, explain: _____
Have you seen a medical doctor for this condition? Y / N
If yes, where?: _____
Have you ever been treated by a chiropractor before? Y / N
If yes, where?: _____

Please circle any areas of pain or discomfort

Is it constant? Y / N Is it dull? Y / N
Is it sharp? Y / N Does it burn? Y / N



Are you on any medications? Y / N If so, what? _____

Do you now or have you ever had any of the following diseases or conditions?

Y N Neck pain	Y N Ear infections	Y N Heart murmur	Y N Digestive problems
Y N Back pain	Y N Chronic colds	Y N Heart defects	Y N Kidney problems
Y N Headache	Y N Asthma	Y N Anemia	Y N Bed-wetting
Y N Arm pain	Y N Allergies	Y N Seizures	Y N ADHD
Y N Leg pain	Y N Sinus problems	Y N Cancer	Y N ADD

Please list any other conditions/diseases not listed above: _____
_____
Please list any serious accidents or surgeries with dates: _____
_____
Family health history: _____