

Today's Date: _____

First & Last Name: _____

Address: _____

Email: _____

Phone: _____ Date of Birth: _____

Male ____ Female ____ Single ____ Married ____ Divorced ____ Widowed ____

Occupation: _____

Employer Name & Address: _____

Spouse's Occupation: _____

Number of Children: _____ Referred By: _____

CHILDHOOD YEARS

Did you have any childhood illnesses? _____

Did you have any serious falls as a child? _____

Did you play youth sports? _____

Did you have any surgery? _____

Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree) _____

Were you involved in any car accidents? _____

Was there any prolonged use of medicine such as antibiotics or an inhaler? _____

Did you suffer any other traumas? (physical or emotional) _____

Were you vaccinated? _____

As a child, were you under regular Chiropractic Care? _____

Comments: _____

ADULT YEARS

Do/did you smoke? _____ Do/did you drink alcohol? _____

Have you been in any accidents? _____ Have you had any surgery? _____

Do/did you play any adult sports? _____ Weight? _____

On a scale from 1-10, describe your stress level: (1 = none, 10 = extreme)

Occupation: _____ Personal: _____

On a scale of Poor, Good, or Excellent, describe your:

	Poor	Good	Excellent
Diet:	_____	_____	_____
Exercise:	_____	_____	_____
Sleep:	_____	_____	_____

General Health _____

ADDRESSING THE ISSUES THAT BRINGS YOU TO THE OFFICE

If you have no symptoms, and are here for wellness services, please check here:

_____ **I wish to have Chiropractic Wellness Service**

(Please skip to "Family Health Profile" further below this form.)

Briefly describe the issue that brings you to the office, including the affect it has had on your life:

Other Doctors seen for this problem (please list):

Chiropractor: _____

Medical Doctor: _____

Other: _____

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Numbness if Fingers | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Sensitive Eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Irritability | <input type="checkbox"/> Mood Swings |

List any medications you are taking:

Family Health Profile:

Please mention below health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Others: _____

The statement on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature: _____ Date: _____

TERMS OF ACCEPTANCE

When one seeks chiropractic health care and is accepted for such care, it is essential for both doctor and patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. The chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and spiritual well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Chiropractors do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, non – chiropractic or unusual findings are encountered, you will be advised.

Regardless of what the disease is called, chiropractors do not offer to treat it. Nor do chiropractors offer advice regarding treatment prescribed by others. The chiropractor's only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. The only method is specific adjusting to correct vertebral subluxations.

I, (print name) _____ have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

(signature of parent or guardian if patient under 18 years old)