



Patient Information

Last Name: _____ First Name: _____ MI: ____ Male/Female (Circle)

Address: _____ City: _____ State: ____ Zip: _____

Email: _____ Home Phone: _____ Cell: _____

Date of Birth: ____/____/____ Age: ____ SSN: ____ - ____ - ____ (Insurance Purposes)

Marital Status: M/S/D/W **Emergency Contact/Phone Number:** _____

Occupation: _____ Employer: _____ Referred By: _____

Spouse Information

Name: _____ Date of Birth: ____/____/____ Employer _____

Health History

Date of last physical exam: ____/____/____ Height: _____ Weight: _____ lbs. Pregnant Y/N?

Describe the purpose of this appointment: _____

Date most recent symptoms started: _____

List any other health problems and treatments: _____

Have you previously received chiropractic care Y/N? How long ago? _____

Do you regularly take any medications Y/N? List medicine and reason you take it: _____

Have you ever had surgery Y/N? Any major falls or accidents Y/N? If yes for either, please list dates and describe:

**Please circle all that apply.*

Musculo-Skeletal System

- Low back problems
- Pain between shoulders
- Neck problems
- Arm/Leg problems
- Swollen/Stiff joints
- Sore/Weak muscles
- Walking problems
- Broken bones

Cardio-Vascular Respiratory

- Chest Pain
- Difficult breathing
- Painful cough
- Rapid heartbeat
- Blood Pressure problems
- Heart problems
- Lung problems
- Pacemaker

Nervous System

- Numbness
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Paralysis

I agree that the following information is accurate and up to date. I authorize the release of any information concerning my health and health care services to any insurance company, health plan, adjustor, or attorney that will assist in the payment of a claim, if applicable.

Patient's Signature: _____ **Date:** _____

If patient is a minor, please sign here for consent to treat: _____