CHIROPRACTIC RECORD

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ PHONE # _____ CELL # _____

CITY _____ STATE _____ ZIP _____ WORK # _____ SPOUSE _____

E-MAIL _____ SPOUSES OCCUPATION _____

BIRTHDATE _____ AGE _____ HGHT _____ WGHT _____ SPOUSES EMPLOYER _____

OCCUPATION _____ AGE(S) OF CHILDREN _____ _____ _____ _____ _____

EMPLOYER _____ REFERRED BY _____

EMERGENCY CONTACT/ PH# _____

MAJOR COMPLAINTS: (A) _____ (B) _____

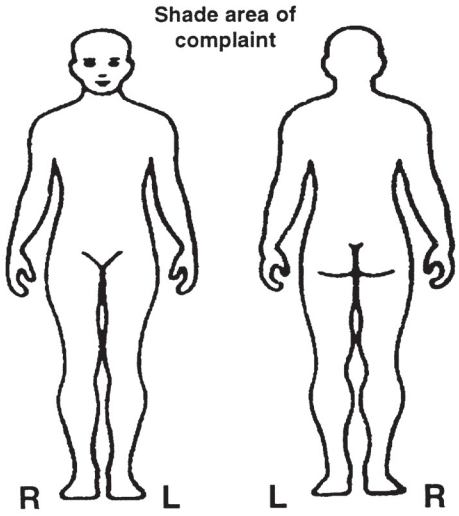
(C) _____ (D) _____ (E) _____

WHICH OF YOUR MAJOR COMPLAINT(S) BOTHERS YOU THE MOST? (CIRCLE ONE OR MORE) A B C D E

How long have you had this condition? _____ Have you had this or a similar condition in the past? _____

How did the problem occur? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Grade your current symptoms below from 1-10, with 10 being the worst. When the problem is at it's worst.



_____ Headaches	_____ Restricts Daily Activities	_____ Allergies
_____ Migraine	_____ Restricts Regular Exercise	_____ Hay Fever
_____ Dizziness	_____ Stiff Joints	_____ Sinus Problems
_____ TMJ / Clicking Jaw	_____ Painful Joints	_____ Asthma
_____ Neck Pain	_____ Loss of Feeling	_____ Eczema / Shingles
_____ Shoulder Problems	_____ Sore Muscles	_____ Ulcers
_____ Arm Problems	_____ Weak Muscles	_____ Diarrhea
_____ Wrist Problems	_____ Muscle Cramps	_____ Constipation
_____ Pain Between Shoulders	_____ Fainting	_____ Nausea
_____ Mid Back Pain	_____ Forgetfulness	_____ Kidney / Bladder Infections
_____ Poor Digestion/Heart Burn	_____ Depression	_____ Menstrual Cramps
_____ Gas / Bloating after Meals	_____ Vision Problems	_____ Diabetes
_____ Low Back Problems	_____ Ear Pain / Infection	_____ High Blood Pressure
_____ Leg Problems	_____ Hearing Loss	_____ Tired / Fatigue
_____ Knee Pain	_____ Loss of Sleep	_____ Cancer
_____ Walking Problems	_____ Frequent Colds	_____ Other

- Have you ever had Chiropractic care before? Yes ☐ No ☐
- Name of Doctor/s: _____ Date: _____
- Last time you had spinal X-rays: _____
- Names of Other Doctor/s: _____
- Treatment: _____
- Have you ever had surgery or been hospitalized? Yes ☐ No ☐

List Surgeries: _____

List Broken Bones: _____

- Medications/Nutrition now taking _____

From birth to present please list by date and describe.

Car Accidents, Falls/Injuries (Including Sports) _____

Patient's/Guardians Signature **Date**