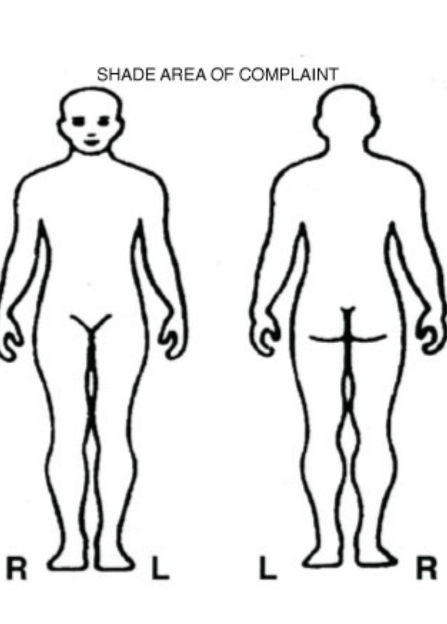
LAST NAME ______________________ FIRST NAME ______________________ MIDDLE ______________
ADDRESS ______________________ CELL # ______________________ WORK # ______________________
CITY ______________ STATE ________ ZIP ____________ SPOUSE'S NAME ______________________
EMAIL ______________________ SPOUSE'S OCCUPATION ______________________
BIRTHDATE ______________ AGE _____ HGT ______ WGHT _______ SPOUSE'S EMPLOYER ______________________
OCCUPATION ______________________ AGE(S) OF CHILDREN ______________________
EMPLOYER ______________________ REFERRED BY ______________________
EMERGENCY CONTACT/PH # ______________________

MAJOR COMPLAINTS: (A) ______________________ (B) ______________________
(C) ______________________ (D)______________________ (E)______________________

WHICH OF YOUR COMPLAINT(S) BOTHERS YOU THE MOST? (CHECK 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



Rate your symptoms (when they're at their worst) from 1-10, with 10 being the worst.

_____ Headaches
_____ Migraine
_____ Dizziness/Vertigo
_____ TMJ/Clicking Jaw
_____ Neck Pain
_____ Shoulder Problems
_____ Arm Pain/Numbness
_____ Wrist Pain/Numbness
_____ Upper Back Pain
_____ Mid Back Pain
_____ Poor Digestion/HeartBurn
_____ Low Back Problems
_____ Leg Pain/Numbness
_____ Knee Pain
_____ Walking Problems

Circle "past" or "present" below for any conditions you have experienced or are experiencing.

Condition			Condition		
Restricts Daily Activities	Past	Present	Constipation	Past	Present
Restricts Regular Exercise	Past	Present	Kidney/Bladder Infections	Past	Present
Muscle Problems	Past	Present	Menstrual Cramps	Past	Present
Fainting	Past	Present	Diabetes	Past	Present
Forgetfulness	Past	Present	Heart Problems	Past	Present
Depression	Past	Present	High Blood Pressure	Past	Present
Ear Pain/Infection	Past	Present	Tired/Fatigue	Past	Present
Loss of Hearing	Past	Present	Cancer	Past	Present
Loss of Sleep	Past	Present	Other ______________		
Frequent Colds	Past	Present	______________		
Allergies	Past	Present	______________		
Sinus Problems	Past	Present	______________		
Asthma	Past	Present	______________		
Shortness of Breath	Past	Present	______________		
Diarrhea	Past	Present	______________		

Have you ever had chiropractic care before? ☐Yes ☐No
Chiropractor(s) Name(s): ______________ Date: ________
Last time you had spinal x-rays: ______________________
MD Name(s): ______________________
Treatment: ______________________
Have you ever had surgery or been hospitalized? ☐Yes ☐No
List Surgeries: ______________________
List Broken Bones: ______________________
Medications/Nutrition currently taking: ______________________
____
____

From birth to present please list by date and describe.
Car accidents, falls/injuries (including sports): ______________________
____
____
____
____
____
____

______________________ ______________
Patient/Guardian Signature Date

LEAVE BLANK