CHIROPRACTIC RECORD

LAST NAME ____________ FIRST NAME ____________ MIDDLE INIT. ____

ADDRESS ____________ PHONE / CELL # ____________

CITY ____________ STATE ______ ZIP ______ WORK # ____________

E-MAIL ____________ SPOUSES NAME ____________

BIRTHDATE ____________ AGE ______ HGHT ______ WGHT ______ SPOUSES OCCUPATION/EMPLOYER ____________

OCCUPATION ____________ AGE(S) OF CHILDREN ____________

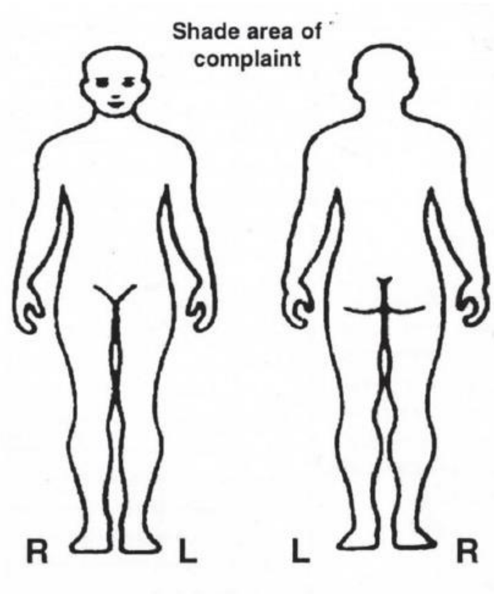
EMPLOYER ____________ REFERRED BY ____________

EMERGENCY CONTACT / PHONE # ____________

MAJOR COMPLAINTS: 1) ____________ 2) ____________

3) ____________ 4) ____________ 5) ____________

DATE & HOW PROBLEM OCCURRED ____________



Rate your symptoms below 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
- ______ Mid Back Pain
- ______ Low Back Pain
- ______ Hip Pain
- ______ Knee Pain
- ______ Foot Pain
- ______ Other ______

Check "**Past**" or "**Present**" below for any conditions you have/had

Condition			Condition		
Restricts Daily Activities	☐ Past	☐ Present	Shortness of Breath	☐ Past	☐ Present
Restricts Regular Exercise	☐ Past	☐ Present	Diarrhea	☐ Past	☐ Present
Muscle Cramps	☐ Past	☐ Present	Constipation	☐ Past	☐ Present
Weak Muscles	☐ Past	☐ Present	Kidney / Bladder	☐ Past	☐ Present
Fainting	☐ Past	☐ Present	Menstrual Cramps	☐ Past	☐ Present
Forgetfulness	☐ Past	☐ Present	Diabetes	☐ Past	☐ Present
Depression	☐ Past	☐ Present	Heart Problems	☐ Past	☐ Present
Ear Pain / Infection	☐ Past	☐ Present	High Blood Pressure	☐ Past	☐ Present
Loss of Hearing	☐ Past	☐ Present	Tired / Fatigue	☐ Past	☐ Present
Loss of Sleep	☐ Past	☐ Present	Cancer	☐ Past	☐ Present
Frequent Colds	☐ Past	☐ Present	Poor Digestion / Heartburn	☐ Past	☐ Present
Allergies	☐ Past	☐ Present	Gas / Bloating after Meals	☐ Past	☐ Present
Sinus Problems	☐ Past	☐ Present	Nausea	☐ Past	☐ Present
Asthma	☐ Past	☐ Present			

Have you ever had Chiropractic care before? ☐ Yes Date: ____________ ☐ No

Chiropractor(s) Name(s): ____________

Last time you had spinal X-rays: ____________

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No

Treatments/Surgeries/Dates: ____________

MD Name(s): ____________

Medications/Nutrition now taking: ____________

From birth to present please list by date and describe.

Car accidents, Falls/Injuries (Including Sports), Fractures

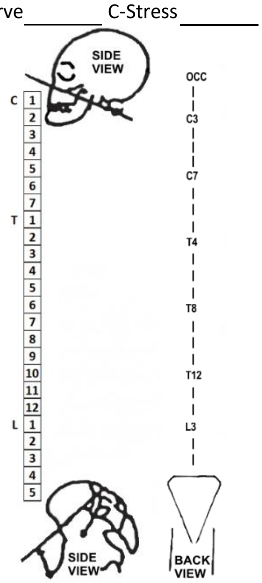
____

Patient's/Guardian's Signature ____________ Date ____________

CHIROPRACTIC BIOPHYSICS X-RAY ANALYSIS

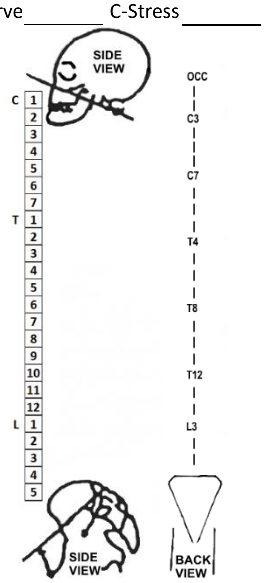
Leave Sections Below Blank

Date ______ Atlas ______ C-Curve ______ C-Stress ______



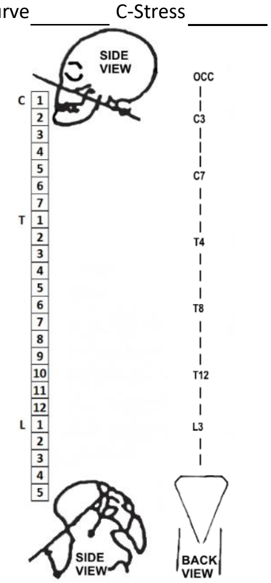
L-Curve ______ L-Stress ______

Date ______ Atlas ______ C-Curve ______ C-Stress ______



L-Curve ______ L-Stress ______

Date ______ Atlas ______ C-Curve ______ C-Stress ______



L-Curve ______ L-Stress ______

EXERCISES / NUTRITION / SUPPLIES

Spinal Molding, Cervical Lumbar Supports ______

Williams Exercises ______

Cervical Compression Exercises ______

Head Lt. Rt. Translation Exercises ______

Pelvis Lt. Rt. Translation Exercises ______

Financial

____

TMT Plan ____________

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