□ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____ Date: _____

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____ City _____

State _____ Zip _____ Cell Phone (_____) _____Work Phone(____)_____

Email _____ Date of Birth _____/_____/_____ Sex : M / F

Social Security Number: _____-_____-_____

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp

□ Auto Insur. □ Medicare □ Medicaid □ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

How did you hear about our office? _____

Social History: (Check all that apply to you)

Drink Alcohol: □ occasional □ often □ never

Tobacco: □ occasional □ often □ never

Dietary History: (check all that apply)

I eat leafy greens such as kale, swiss chard, collard greens, spinach □ daily □ weekly □ rarely/never

I drink at least five glasses of water □ daily □ weekly □ rarely/never

I eat fast food : □ daily □ weekly □ rarely/never

I eat red meat and dairy products: □ daily □ weekly □ rarely/never

I eat the recommended amount of fruits and vegetables: □ yes □ no □ sometimes

I take a high quality multi-vitamin: □ yes □ no Please list type/brand: _____

Please list all current medications: _____

_____

Please list all supplements? _____

_____

Are you pregnant? Yes_____ No _____N/A_____

Family History: (Check all that apply)

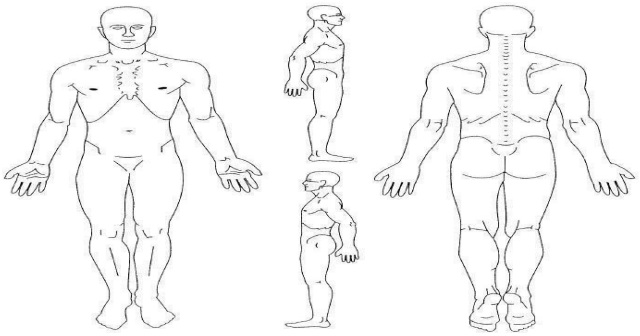
Arthritis:	□ Parent	□ Sibling	Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling	Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling	Stroke	□ Parent	□ Sibling

Other _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol								**Ear, Nose and Throat**	Past	Present	No
Pace Maker								Difficulty Swallowing			
Jaw Pain								Dizziness			
Irregular Heartbeat								Hearing Loss			
Swelling of legs								Sore Throat			
								Nosebleeds			
Genitourinary	Past	Present	No	**Psychiatric**		Present	No	Bleeding Gums			
Kidney Disease				Depression				Sinus Infections			
Burning Urination				Anxiety							
Frequent Urination				Stress				**Gastrointestinal**	Past	Present	No
Blood in Urine								Gall Bladder Problems			
Kidney Stones				**Endocrine**	Past	Present	No	Bowel Problems			
Lower Side Pain				Thyroid				Constipation			
				Diabetes				Liver Problems			
Neurologic	Past	Present	No	Hair Loss				Diarrhea			
Stroke				Menopausal				Nausea/Vomiting			
Seizures				Menstrual				Bloody Stools			
Head Injury								Poor Appetite			
Brain Aneurysm				**Hematologic**	Past	Present	No	Ulcers			
Numbness				Hepatitis							
Severe Headaches				Blood Clots							
Pinched Nerves				Cancer							
Parkinson's				Bruising							
Carpal Tunnel				Bleeding				**Musculoskeletal**	Past	Present	No
Vertigo				Fever, Chills				Gout			
				Sweating				Arthritis			
Constitutional	Past	Present	No					Joint Stiffness			
Weight Loss/Gain								Muscle Weakness			
Low Energy								Osteoporosis			
Sleep problems								Broken Bones			
								Joints Replaced			

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:



N=Numbness B=Burning S=Stabbing
T=Tingling A=Dull Ache

Rate your pain (circle one, 0=no pain, 10= bad pain):
1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? (mo/day/yr) _____

Are your symptoms a result of: Circle One Motor Vehicle Accident □ Work related Accident
How are your symptoms changing? Circle One Getting better □ Not changing □ Getting worse
Describe your symptoms in order of severity, with worse symptom being #1: _____
_____

Daily Activities: Effects of Current Condition on Performance (circle your answers)

Bending:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Carrying Groceries:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Change Posn–Sit-Stand:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Climb Stairs:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Driving:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Extended Computer Use:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Household Chores:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Kneeling:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Lifting:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Reading (Concentration):	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Sexual Activities:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Sleep:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Sitting:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Standing:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Walking:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Yard Work:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information. These are available at Reception or on the table in the Reception area.

Print Patient's Name _____Patient's Signature_____Date:_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Parent's Signature Authorizing Care _____ Date_____

SIGNATURE OF PHYSICIAN: _____Date: _____