



Date: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_  
(Number) (Street) (City) (State & Zip)

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Social Security Number \_\_\_\_\_ Primary Doctor \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Marital Status \_\_\_\_\_

Spouse's Name/Phone # \_\_\_\_\_

Insured Name (if different from above): \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Guarantor (if different from above): \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Have you had previous chiropractic care? \_\_\_\_\_ Who referred you to this office? \_\_\_\_\_

Please list:

Any surgeries \_\_\_\_\_

Major accidents/falls \_\_\_\_\_

Family history (illness such as tuberculosis, diabetes, cancer, high blood pressure, etc. for yourself and immediate family) \_\_\_\_\_

FEMALE HISTORY: Date of last menstrual cycle \_\_\_\_\_ Regular \_\_\_\_\_ Irregular \_\_\_\_\_

Do you take birth control pills? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Have you previously sought medical treatment for you complaints? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Doctors previously seen \_\_\_\_\_

Are your complaints related to an accident? \_\_\_\_\_ Yes \_\_\_\_\_ NO \_\_\_\_\_ Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_

**If this is an accident or work related injury please ask the receptionist for additional forms.**

Race (circle only one) American Indian Alaska Native  
Asian White  
Black or African American Native to Hawaiian  
Other Pacific Islander Declined to State

Ethnicity (circle only one) Hispanic or Latino Not Hispanic or Latino  
Declined to State

Smoking Status (circle only one) Current Every Day Smoker Smoking Start Date: \_\_\_\_\_ End Date \_\_\_\_\_  
Current Some Day Smoker  
Former Smoker  
Never Smoker

In effort to quit smoking, I am currently taking: \_\_\_\_\_

Do you have any allergies to medication? Yes No

If yes, please indicate the following:

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Are you currently taking any medication? Yes No

If yes, please indicate the following:

Medication: \_\_\_\_\_  
Route: Oral  
Intravenous  
Other: \_\_\_\_\_

Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued use: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route: Oral  
Intravenous  
Other: \_\_\_\_\_

Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued use: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route: Oral  
Intravenous  
Other: \_\_\_\_\_

Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued use: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route: Oral  
Intravenous  
Other: \_\_\_\_\_

Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued use: \_\_\_\_\_

**Major Complaints: (Be Specific)**

A) \_\_\_\_\_  
\_\_\_\_\_  
B) \_\_\_\_\_  
\_\_\_\_\_  
C) \_\_\_\_\_  
\_\_\_\_\_

D) \_\_\_\_\_  
\_\_\_\_\_  
E) \_\_\_\_\_  
\_\_\_\_\_  
F) \_\_\_\_\_  
\_\_\_\_\_

**Medications:** \_\_\_\_\_

1. Which of your major complaints bother you the most (Check one or more) [ ] A [ ] B [ ] C [ ] D [ ] E [ ] F
2. How long have you had this complaint(s)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Prior to the problem beginning, did you ever have an earlier problem that was the same or similar?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Did it appear [ ] Slowly? [ ] Immediately?
5. Does anyone else in your family have this problem or a similar one? \_\_\_\_\_  
\_\_\_\_\_
6. How often does it bother you now? \_\_\_\_\_
7. When it is at its worst, how does it feel? \_\_\_\_\_
8. When it is at its worst, how does it interfere with your normal daily activities? \_\_\_\_\_  
\_\_\_\_\_
9. Does this problem reduce your productivity or effectiveness regarding your work? \_\_\_\_\_  
\_\_\_\_\_
10. Does it create any problems with your relationships? [ ] YES [ ] NO  
If yes, how? \_\_\_\_\_
11. What have you done to aggravate the problem and/or what have you failed to do that would have helped get rid of it?  
\_\_\_\_\_  
\_\_\_\_\_
12. If your problem was left unhandled for five years, how do you think it would affect you? \_\_\_\_\_  
\_\_\_\_\_
13. Are you committed to getting rid of not only your symptom(s) but what caused it, even if it requires a change in your life-style? [ ] YES [ ] NO
14. (If Children) Tell me about your children: \_\_\_\_\_  
\_\_\_\_\_

**Auto Accident:** \_\_\_\_\_

Personal Injury (PI) [ ] YES [ ] NO      Head Position [ ] Straight Ahead [ ] Rotated (Which Way?) \_\_\_\_\_  
MPH on Impact \_\_\_\_\_ Amount of Damage to Vehicle \_\_\_\_\_ Ft. of Acceleration \_\_\_\_\_  
Kind of Car \_\_\_\_\_ Their Car \_\_\_\_\_ Position of Head Rest \_\_\_\_\_