PATIENT NAME:_____ _____**DATE:**_____

PURPOSE FOR TODAY'S APPOINTMENT (check all that apply):

□ Wellness Care □ Nutrition Consultation □ Headaches/TMJ □ Auto Accident
□ Work Injury □ Pain in _____ □ Sinus problems □ Orthotics

Doctors you have seen for the above condition_____

Have you ever had chiropractic care? □YES □NO. Date of my last visit was _____ with Dr. _____

Have you been treated for **any** health condition in the last year? □YES □NO. I was treated for _____
_____

Who is your primary care physician? _____

CURRENT HEALTH

What **prescription drugs** are you currently taking? (Pain/muscle relaxers, blood pressure, insulin, hormone replacement etc). _____

What **over-the-counter** medications are you currently taking? (aspirin, Ibuprofen, antibiotics, etc)_____

What **vitamins, minerals or herbs** are you currently taking?_____

Are you currently on a **regular aerobic exercise program**? □Yes □No If yes, describe_____

Coffee or pop please list how much and how often you drink each_____

Rate your **Stress Level** □Mild □Moderate □Severe □Unbelievable

How much **Water** do you drink per day? _____

Alcohol, cigarettes or chewing tobacco, please list how much and how often you use these_____
_____

Do you currently have (or have you had in the past 6 months) any of the following:

MUSCULO-SKELETAL
___Low back pain
___Pain between shoulders
___Neck pain
___Arm pain
___Leg Pain
___Joint Pain/Stiffness
___Walking Problems
___Difficulty chewing
___Clicking Jaw

NERVOUS SYSTEM
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion/Depression
___Convulsions
___Cold hands/feet

URINARY
___Bladder trouble
___Painful/excessive urination
___Discolored Urine

CARDIOVASCULAR
___Chest Pain
___Shortness of breath
___Blood pressure problems
___Irregular heartbeat
___Heart problems
___Lung problems
___Varicose veins
___Ankle swelling

GENERAL
___Allergies
___Loss of Sleep
___Fever

EAR/EYE/NOSE/THROAT
___Fainting
___Vision problems
___Dental problems
___Sore throat
___Earaches
___Hearing difficulty
___Stuffed Nose
___Sinus problems

MALE/FEMALE
___Menstrual irregularity
___Menstrual cramping
___Vaginal pain/infections
___Breast pain/lumps
___Prostate Dysfunction
___Genital Herpes
___Sexual Dysfunction

FEMALES ONLY: Date of last period?_____
Are you pregnant? □Yes □No □Maybe

GASTRO-INTESTINAL
___Poor/Excessive appetite
___Excessive thirst
___Frequent nausea
___Vomiting
___Diarrhea
___Constipation
___Hemorrhoids
___Liver trouble
___Gallbladder problems
___Weight trouble
___Abdominal cramps
___Gas/bloating after meals
___Heartburn
___Black/blood in stool
___Colitis

HEALTH HISTORY

Please list all **accidents** (auto, work injuries, significant slips or falls, etc.) you have had in your lifetime:
_____

Please list all **surgeries** you have had in your lifetime:

_____

_____

Please list all **hospitalizations** you have had in your lifetime (pneumonia, childbirth, etc.):

_____

_____

Please list all **broken bones and x-rays** you have had in your lifetime:

_____

_____

Have you had any of the following in your lifetime?

_____Appendicitis	_____Polio	_____Arthritis	_____Cancer
_____Chicken Pox	_____Tuberculosis	_____Back Pain	_____Heart Disease
_____Measles	_____Small Pox	_____Pleurisy	_____Alcoholism
_____Mumps	_____Typhoid Fever	_____Pneumonia	_____Venereal Infection
_____Whooping Cough	_____Scarlet Fever	_____Influenza	_____Anemia
_____Diphtheria	_____Rheumatic Fever	_____Goiter	_____Epilepsy
_____Diabetes	_____Malaria	_____Eczema	_____Mental Disorder