PATIENT NAME:_____**DATE:**_____

TODAY'S APPOINTMENT

Purpose for today's appointment (check all that apply):

- ☐ Wellness Care
- ☐ Nutrition Consultation
- ☐ Need a Family Doctor
- ☐ Headaches or TMJ
- ☐ Auto Accident
- ☐ Work Injury
- ☐ Pain in _____
- ☐ Sinus problems
- ☐ TMJ
- ☐ Lab Work
- ☐ Other _____

Doctors you have seen for the above condition_____

Have you ever had chiropractic care? ☐NO ☐YES. Date of last visit _____with Dr. _____

_____

Have you been treated for **any** health condition in the last year? ☐NO ☐YES. If yes, please describe _____

_____

Who is your primary care physician? _____

CURRENT HEALTH

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

What **over-the-counter** medications are you currently taking? (Aspirin, Ibuprofen, cold medicine, etc)_____

_____

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

Have you taken **antibiotics** in the past 12 months? ☐No ☐Yes If yes, reason_____

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

If you drink **coffee or pop**, please list how much and how often you drink each_____

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

If you use **alcohol, cigarettes or chewing tobacco**, please list how much and for how long_____

_____

Please rate your **stress level** on a scale of 1-10 (1 = no stress, 10 = extreme stress) _____

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

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

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

For office use:
M4 _____
Scan _____
OM _____

PATIENT NAME:_____**DATE:**_____

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 (excluding annual dental x-rays):

_____

_____

_____

Have you had any of the following in your lifetime?

_____Appendicitis	_____Polio	_____Arthritis	_____Cancer
_____Chicken Pox	_____Tuberculosis	_____Lumbago	_____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

How Can We Best Serve YOU?

Some people go to a chiropractor to eliminate a pain or symptoms (**Relief Care**). Others, not only want to get rid of the pain or symptoms, but want to correct the underlying cause in order to reduce the chance of the problem returning (**Corrective Care**). Increasingly, others want to achieve the highest level of ongoing health and wellness they can (**Wellness Care**).

To best serve your needs and wishes, please select which type of care you prefer.

(Please check one box only)

☐ **RELIEF CARE** (I am only here for pain relief)

☐ **CORRECTIVE CARE** (I want to correct the *cause* of the problem so the pain does not return)

☐ **WELLNESS CARE** (I want to be disease free and as healthy as possible)

☐ **I WANT TO LEAVE THIS DECISION TO MY DOCTOR, SO HE MAY SELECT THE MOST APPROPRIATE TYPE OF CARE FOR MY CONDITION.**

For office use:
M4 _____
Photo_____
Scan _____
OM _____