Natural Healing Through Chiropractic Care

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Thank you for choosing or	ur practice for y	our chiropractic nee	ds. Please complete	this form	in ink. If you	have any questions
concerns, do not hesitate t	to ask for assisi	tance. We vill be hap	py to help.			
(Please Print)						
Name			Patie	ent No		_ S/S
First	MI	Last				
Address		Cit	у		State	Zip
Sex: Female	Male					
Birth date						#
Do you prefer to receive						
Are you:						
Your employer			Occupation _			
Business Address						
Spouse's or parent's nar	me		Workplace		Work p	hone #
Whom may we thank fo						
Person to contact in cas	e of emergenc	у		Pho	one #	
Physia N						
Responsible Name of person respons Relationship to patient	sible for this a					
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Symptoms		***		
Reason for visit		When did you ti	rst notice the symptoms?	
ls this condition gettin	g progressively worse?			
where specifically is the	he problem(s) located? fficult to perform? 3 Sittir	a T Standing T Walking	na Dendina Divina	lown Ti Othar
	arp Dull IIT			
	arming 3 Tingling 3 C			_
Dota the cavacity of yo	ur pain. (I, mild pain or dis	comfort to 10 severe nair		7 8 9 10
hate the severity of yo	does it come and go?	connort. to 10, severe pair	117. 1 2. 3 4 3 0	7 0 7 10
Uhat treatment have v	ou already received for you	r condition?		
☐ Medication	Surgery 3 Physic	al Therapy Dube	er	
	other doctor(s) who have tre			
. varite and address of t	diet doctor(3) who have de	anca you for your condition	7.11.	
Health Hist	ory			
	litions which are applicable	:		
□ AIDS/HTV	☐ Cataracts	☐ Hepatitis	→ Osteoporosis	☑ Suicide Attempt
Alcoholism	Chemical Dependency	J Hemia	☐ Pacemaker	Thyroid Problem
J Allergy Shots	Chicken Pox	THerniated Disc	☐ Parkinson's Disease	Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	Tumors. Growth
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	J Polao	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	Vaginal Infection
☐ Bleeding Disorders	☐ Glaucoma	Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disea
☐ Breast Lump	☐ Goiter	☐ Miscarriage	Rheumatoid Arthritis	Whooping Cou
☐ Bronchitis	☐ Gonorthea	J Mononucleosis	☐ Rheumatic Fever	🕽 Other
☐ Bulimia	J Gout	☐ Multiple Sclerosis	2 Scarlet Fever	
☐ Cancer	☐ Heart Disease	T Mumps	□ Stroke	
Dates of last exams _				
. , ,	mant? I Yes I No Nu	•	•	Yes 🗅 No
List any types of surge	ries which you have had an	d the dates which they occ	curred:	
Please list all medicati	ons you are currently taking	g:		
Allergies:				
Allergies: Daily Habit	S			
Allergies: Daily Habit	S do you perform on a daily t	basis? I None	☐ Moderate ☐ Hea	wy
Allergies: Daily Habit What type of exercise	S do you perform on a daily took habits include? (ex: sitti			•
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