# PERSONAL INFORMATION

LAST NAME: <1000034>

FIRST NAME: <1000031> \_ MI: <1000033>

GENDER: MALE / FEMALE BIRTHDAY: <1000041> / <1000042>/<1000043> AGE: <1000074>

SOCIAL SECURITY NUMBER: <1000046>

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPERATED WIDOWED

SPOUSES NAME: <1000107>

EMERGENCY CONTACT: NAME: <1000093> PHONE: <1000095>

WHO REFERRED YOU?: <1000195> <1000196>

# CONTACT INOFRMATION

ADDRESS: <1000044>

CITY: <1000062> STATE: <1000063> ZIP CODE: <1000064>

HOME PHONE: <1000039>

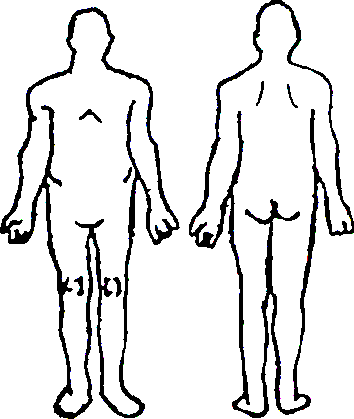
CELL PHONE: <1000037>

HOME EMAIL ADDRESS: <1000065>

WORK: PHONE: <1000123> EMAIL: <1000129>

# CONDITION INFORMATION

REASON FOR VISIT: MARK AREAS OF SYMPTOMS:

DATE SYMPTONS STARTED?: GETTING WORSE OR BETTER?: RATE PAIN 0-10: TYPE OF PAIN: SHARP / DULL / BURNING / CRAMPING / THROBBING MY PAIN INTERFERES WITH: WORK / SLEEP / DAILY ROUTINE / RECREATION FREQUENCY OF MY PAIN: CONSTANT / COMES AND GOES

CHIROPRACTIC GOALS?:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCIDENT?: YES / NO AUTO / HOME / WORK / OTHER

PATIENT NAME: <1000282> DATE: <1000110>

# HEALTH HISTORY

CARE CURRENTLY RECEIVING: CHIROPRACTIC / MASSAGE / MEDICATION / SURGERY / OTHER:

LAST DATE OF: SPINAL EXAM:

XRAY:

MRI:

BONE SCAN:

PLEASE CIRCLE ANY CONDITIONS THAT YOU CURRENTLY SUFFER FROM, AND CHECK ANY THAT YOU PREVIOUSLY HAD:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AIDS/HIV | ALCOHOLISM | ALLERGY SHOTS | ANEMIA | ANOREXIA |
| APPENDICITIS | ARTHRITIS | ASTHMA | BLEEDING | BREAST LUMP |
| BRONCHITIS | BULIMIA | CANCER | CATARACTS | CHEMICAL DEPENDENT |
| CHICKEN POX | DIABETES | EMPHYSEMA | EPILEPSY | FRACTURES |
| GLAUCOMA | GOITER | GONORRHEA | GOUT | HEART DISEASE |
| HEPATITIS | HERNIA | HERNIATED DISCO | HERPES | HIGH CHOLESTEROL |
| KIDNEY DISEASE | LIVER DISEASE | MEASLES | HEADACHES | MISCARRIAGE |
| MONO | MS | MUMPS | OSTEOPOROSIS | PACEMAKER |
| PARKINSONS | PINCHED NERVE | PNEUMONIA | POLIO | PROSTATE PROBLEM |
| PROTHESIS | PSYCHIATRIC CARE | RHEUMATOID ARTH | RHEUMATIC FEVER | SCARLET FEVER |
| STROKE | SUICUDE ATTEMPT | THYROID PROBLEM | TONSILLITIS | TB |
| TUMORS, GROWTHS | TYPHOID FEVER | ULCERS | VAGINAL INFECTIONS | VENEREAL DISEASE |
| WHOOPING COUGH | COLDS | FLU | VIRAL INFECTIONS | VISION PROBLEMS |
| FIBROMYALGIA | MIGRAINES | OTHER |  |  |

# ACTIVITY

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EXERCISE** |  |  | **WORK ACTIVITY** | |  |  |  | **HABITS** |  |
| NONE |  | SITTING |  | HOURS A DAY? |  | SMOKING |  | HOW OFTEN? |  |
| MODERATE |  | STANDING |  | HOURS A DAY? |  | ALCOHOL |  | HOW OFTEN? |  |
| DAILY |  | LIGHT LABOR |  | HOURS A DAY? |  | CAFFINE |  | HOW OFTEN? |  |
| EXTREME SPORT |  | HEAVY LABOR |  | HOURS A DAY? |  | STRESS |  | HOW OFTEN? |  |

**INJURIES / SURGERIES**

FALLS: DATE: HEAD INJURIES / WHIPLASH: DATE: FRACTURES / DISLOCATIONS: DATE: SURGERIES: DATE: CANCER: DATE:

# MEDICATIONS / VITAMINS / HERBS / MINERALS

PLEASE LIST ALL MEDICATIONS, VITAMINS, HERBS AND MINERALS THAT YOU ARE CURRENTLY TAKING:

**I HEREBY AUTHORIZE THE DOCTOR; AND/OR HIS ASSOCIATES TO EXAMINE ME, AND TO PERFORM ANY NECESSARY DIAGNOSTIC PROCEDURES, INCLUDING X-RAY TO FULLY EVALUATE MY CONDITION FOR THE PRESENCE OF VERTEBRAL SUBLUXATION.**

PATIENT SIGNATURE: DATE: <1000110>