

**Is it okay to call you at work?**

- Yes  No

**How did you hear about our clinic? Or who referred you?**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney         | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class   |
| <input type="checkbox"/> Friend        | <input type="checkbox"/> Yellow Pages     | <input type="checkbox"/> Billboard         | <input type="checkbox"/> Brochure       |
| <input type="checkbox"/> Physician     | <input type="checkbox"/> Newspaper ad     | <input type="checkbox"/> TV Commercial     | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer      | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio             | <input type="checkbox"/> Other          |

**If you selected 'Yellow Pages' please indicate which Yellow Pages:**

\_\_\_\_\_

**If you selected 'family member', 'friend', or 'physician' please enter their name below:**

\_\_\_\_\_

**If you selected 'other' please describe**

\_\_\_\_\_

**Social History:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally   | <input type="checkbox"/> Caffeine used often            | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often           |
| <input type="checkbox"/> Drink alcohol occasionally   | <input type="checkbox"/> Drink alcohol often            | <input type="checkbox"/> Exercise not at all       | <input type="checkbox"/> Exercise occasionally        |
| <input type="checkbox"/> Exercise often               | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often   | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always         | <input type="checkbox"/> Wear seat belts never     | <input type="checkbox"/> Wear seat belts usually      |

**Family History:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent)      | <input type="checkbox"/> Arthritis (sibling)      | <input type="checkbox"/> Cancer (parent)              | <input type="checkbox"/> Cancer (sibling)              |
| <input type="checkbox"/> Cholesterol (parent)    | <input type="checkbox"/> Cholesterol (sibling)    | <input type="checkbox"/> Diabetes (parent)            | <input type="checkbox"/> Diabetes (sibling)            |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent)    | <input type="checkbox"/> Psychiatric (sibling)    | <input type="checkbox"/> Stroke (parent)              | <input type="checkbox"/> Stroke (sibling)              |
| <input type="checkbox"/> Thyroid (parent)        | <input type="checkbox"/> Thyroid (sibling)        |   |  |

Do you have children?  Yes  No If yes, how many children \_\_\_\_\_

**What treatment did you receive for your symptoms?**

- |                                      |   |                                     |                                  |
|--------------------------------------|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Adjustments | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Other _____ |   |                                     |                                  |

**When did you receive this treatment?**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> In the last month | <input type="checkbox"/> 2 - 3 months ago | <input type="checkbox"/> 3 - 6 months ago | <input type="checkbox"/> 6 months to 1 year ago |
| <input type="checkbox"/> 1 - 2 years ago   | <input type="checkbox"/> 2 - 5 years ago  | <input type="checkbox"/> 5 - 10 years ago |   |

**What tests have you had for your symptoms?**

- |                                 |                              |                                  |                                |
|---------------------------------|------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> MRI | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Other |
|---------------------------------|------------------------------|----------------------------------|--------------------------------|

**When were these tests done?**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> In the last month | <input type="checkbox"/> 2 - 3 months ago | <input type="checkbox"/> 3 - 6 months ago | <input type="checkbox"/> 6 months to 1 year ago |
| <input type="checkbox"/> 1 - 2 years ago   | <input type="checkbox"/> 2 - 5 years ago  | <input type="checkbox"/> 5 - 10 years ago |   |

**Have you had similar symptoms in the past?**

- Yes  No

**If you have seen treatment in the past for the same or similar symptoms, who did you see?**

This Office                       Other Chiropractor                       Medical Doctor                       Physical Therapist

Other \_\_\_\_\_

**Have you ever had any accidents, falls, auto accidents, etc. that could have contributed to your current condition?**

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

**Are you currently taking medications:**  Yes  No

**List Medications:**

**For What Condition?**

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

**Do you take Vitamins?**  Yes List: \_\_\_\_\_  No

**Do you have hobbies that strain your spine?**  Golf  Bowling  Needlepoint  Horses  Reading in Bed

Other \_\_\_\_\_

**What surgeries have you had ever to your spine, joints, bones; or in the last year to any other body part?**

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

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

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

**Is there any chance you could be pregnant?**  Yes (Date of last period \_\_\_\_\_)  No  Not Applicable

**Have you ever been to a chiropractor before?**  Yes  No

If Yes: Clinic/Dr. Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

For What Condition: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Received by:** \_\_\_\_\_

**NOTES:** \_\_\_\_\_

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