PATIENT NAME_____ AGE_____ BIRTHDATE_____ GENDER_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____ CELL #_____

EMAIL_____ WOULD YOU LIKE TO BE ADDED TO OUR NOTIFICATION LIST? YES OR NO

OCCUPATION_____ EMPLOYER_____

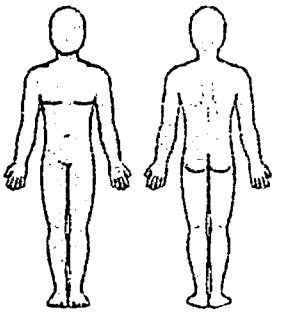
WORK #_____ HEALTH PLAN_____ SUBSCRIBER ID#_____

GROUP #_____ SPOUSE NAME_____

THEIR EMPLOYER_____ CITY_____ ZIP_____

PRIMARY CARE PHYSICIAN NAME_____ PCP PHONE#_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



CURRENT PROBLEM AND HOW IT BEGAN:

☐HEADACHE ☐NECK PAIN ☐MID-BACK PAIN ☐LOW BACK PAIN ☐OTHER_____

DATE PROBLEM BEGAN_____ HOW PROBLEM BEGAN_____

IS THIS: ☐WORK RELATED ☐AUTO RELATED ☐N/A

CURRENT COMPLAINT (HOW YOU FEEL TODAY):

0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE PAIN

HOW OFTEN ARE YOUR SYMPTONS PRESENT? ☐0-25% ☐26-50% ☐51-75% ☐76-100%

IN THE PAST WEEK, HOW MUCH HAS YOUR PAIN INTERFERED WITH YOUR DAILY ACTIVITIES (e.g. work, social act., or household chores)?

0 1 2 3 4 5 6 7 8 9 10

NO INTERFERENCE UNABLE TO CARRY ON ANY ACTIVITY

IN GENERAL, OVERALL HEALTH RIGHT NOW IS? ☐EXCELLENT ☐VERY GOOD ☐GOOD ☐FAIR ☐POOR

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? YES OR NO WHAT AREA(S) WERE) TAKEN_____

DATE TAKEN?_____

PLEASE CHECK ALL THAT APPLY TO YOU:

ALCHOL/DRUG DEPENDENCE ☐	HIGH BLOOD PRESSURE ☐	PAIN AT NIGHT ☐	DIZZINESS/FAINTING ☐	STROKE: -DATE: ☐
DIABETES ☐	NUMBNESS IN GROIN/BUTTOCKS ☐	MENSTRUAL PROBLEMS ☐	PAIN UNRELIEVED BY POSITION OR REST ☐	URINARY PROBLEMS ☐
CANCER/ TUMOR (EXPLAIN): ☐	CURRENTLY PREGNANT: - # OF WEEKS: ☐	MEDICATIONS: ☐	ABNORMAL WEIGHT: GAIN OR LOSS CIRCLE ONE ☐	TOBACCO USE- TYPE- A DAY: ☐
	MARKED MORNING PAIN/ STIFFNESS ☐	OSTEOPOROSIS ☐	EPILEPSY/SEIZURES ☐	PROSTATE PROBLEMS ☐
TAKING BIRTH CONTROL ☐	SURGERIES: ☐	VISUAL DISTURBANCES ☐	RECENT FEVER ☐	CORTICOSTEROID USE (CORTISONE PREDISONE, ETC.) ☐

INITIAL HEALTH STATUS- CHIROPRACTIC

I CERTIFY TO THE BEST OF MY KNOWLEDGE; THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. IF THE HEALTH PLAN INFORMATION IS NOT ACCURATE, OR IF I AM NOT ELIGIBLE TO RECEIVE A HEALTH CARE BENEFIT THROUGH THIS PRACTIONER, I UNDERSTAND THAT I AM LIABKE FOR ALL CHARGES FOR SERVICE RETREIVED AND I AGREE TO NOTIFY THIS PRACTIONER IMMEDIATLEY WHENEVER I HAVE CHANGES IN MY HEALTH CONDITION OR HEALTH PLAN COVERAGE IN THE FUTURE. I UNDERSTAND THAT MY CHIROPRACTOR MAY NEED TO CONTACT MY PHYSICIAN IF MY CONDITION NEEDS TO BE CO-MANAGED. THEREFORE, I GIVE AUTHORIZATION TO MY CHIROPRACTOR TO CONTACT MY PHYSICIAN IF NECESSARY.

PATIENT SIGNATURE_____ DATE_____