



Name: _____ Age: _____ Date: _____

Birth Date: _____ Male: _____ Female: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Work: () _____ Cell: () _____

Email Address: _____

Occupation: _____

Employer Name: _____

Single: _____ Married: _____ Spouse's Name: _____

Have you seen a Chiropractor Before? Yes _____ No _____ If yes, when? _____

Whom may we thank for referring you to our office? Or how did you hear of us? _____

YOUR HEALTH SUMMARY

Please check all symptoms related to your current problem.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Light bothers you | <input type="checkbox"/> Problem urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking _____

List any surgeries you've had _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____