

Personal History

Last Name: _____ First: _____ MI: _____

Sex: Male / Female (circle one)

Marital Status: single married divorced widowed

Address: _____ Zip Code: _____

City: _____ State: _____

Date of Birth: ____/____/____ Age: _____

SS#: _____ - _____ - _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ E-mail Address: _____

Your Employer: _____

Type of Work: _____

Name of Spouse: _____

Spouses Employer: _____

Type of Work: _____

Spouses SS#: _____ - _____ - _____

Spouses D.O.B: ____/____/____

Ages of Children: None _____

How were you referred to our office?

MD Yellow Pages Web Site Mailer Event If referred, see below

So that we may properly thank them, who has recommended our office:

Emergency Contact Person: _____

Phone: _____ Relationship: _____

Current / Past Health History

1. Is your condition related to a work, auto, or other injury?

Yes No If yes, then see the assistant now for other paperwork

2. If you have had an injury, when did it happen?

NA ____/____/____

3. Circle the type of treatment you have received for this condition

None Medical Chiropractic Other: _____

4. For each type of treatment, did it help?

Yes No Some For awhile

5. If you have received chiropractic care, how long and often did you go?

6. Provide names of the doctors you have seen for this:

7. Who is your primary care physician?

May we contact / send report to this doctor? Yes No

Systems Review: Mark if you currently have problems with:

Chest Pain	Y N	Weight	Y N	Fevers	Y N
Breathing	Y N	Thirst	Y N	Appetite	Y N
Veins	Y N	Menstrual	Y N	Vomiting	Y N
Depression	Y N	Cramps	Y N	Constipated	Y N
Dizziness	Y N	Lungs	Y N	Heartburn	Y N
Fainting	Y N	Blood Pressure	Y N	Urination	Y N
Hearing	Y N	Swelling	Y N	Breast Pain	Y N
Dental	Y N	Memory	Y N	Joint Pain	Y N
Gas	Y N	Confusion	Y N	Joint Stiff	Y N
Cold Hand	Y N	Vision	Y N	Jaw	Y N
Allergies	Y N	Sinuses	Y N	Drugs	Y N
Headache	Y N	Throat	Y N	Alcohol	Y N
Nausea	Y N	Stools	Y N		
Diarrhea	Y N	Fatigue	Y N		

Street drugs cause problems that may require a different technique. Please notify the doctor, your information is confidential.

Pain Diagram

Draw where you hurt and note what it feels like – sharp, ache, burn, numb or other.

