Please complete this two-page form to the best of your ability in BLACK ink.
Your doctor will use this info to better direct your exam and care. Thank you!

Health History

Name_____ Sex M F Date_____

Address and City_____ State_____ Zip_____

Cell Phone _____ Other Phone_____ Date of Birth_____ Age_____

Social Security #_____ Employer: _____

Emergency Contact: _____ Phone: _____

Have you ever received Chiropractic Care? Yes No If YES, when/where? _____

1. Primary reason(s) for seeking chiropractic care NOW:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint NOW: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Yes / No If YES, where? _____

Do you have any numbness or tingling in your body? Yes / No If YES, where? _____

Grade Intensity/Severity: 0 1 2 3 4 5 6 7 8 9 10 (0 = No pain; 10 = Worst pain imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you have sought for your complaint: _____

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which bones? _____

C. Allergies: _____

D. Medications:

Medication	Reason for taking medication

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parent's or sibling's death	Age at death

6. Social and Occupational History:

A. Level of Education:

O High School diploma/GED O Some College O College Graduate O Post-graduate (MS, PhD, MD)

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient: _____ Signature: _____ Date: _____

Doctor: _____ Signature: _____ Date: _____