

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender: M / F  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Patient Primary Language \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Health Plan \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Spouse Name \_\_\_\_\_  
Spouse Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Care Physician Name \_\_\_\_\_ PCP Phone \_\_\_\_\_

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

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

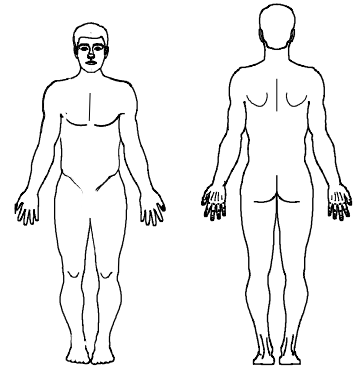
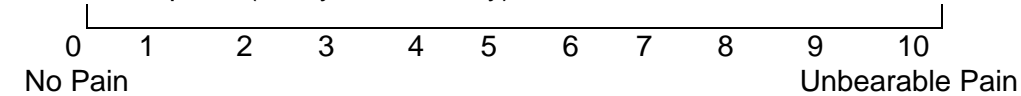
- Headache  Neck Pain  Mid-Back Pain  Low Back Pain  
 Other \_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

Date Problem Began \_\_\_\_\_

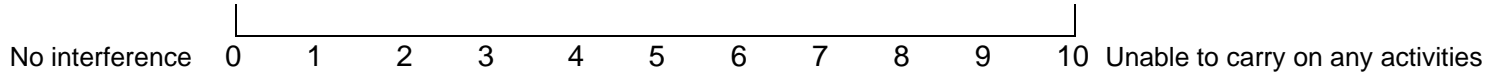
**How Problem Began**

Current complaint (how you feel today):



How often are your symptoms 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 activities, or household chores?)



In general would you say your 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?**  No  Yes

Date(s) taken \_\_\_\_\_ What areas were taken? \_\_\_\_\_

Please check all of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence                          | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Currently Pregnant, # Weeks _____   |
| <input type="checkbox"/> Stroke (Date) _____                              | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Taking Birth Control Pills                       | <input type="checkbox"/> Pain Unrelieved by Position or Rest   |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Pain at Night   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Visual Disturbances   |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____                     | <input type="checkbox"/> Surgeries _____   |
| <input type="checkbox"/> _____  |  |
| <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Tobacco Use - Type _____  |
| <input type="checkbox"/> Epilepsy/Seizures                                | Frequency _____/Day  |
| <input type="checkbox"/> Other Health Problems (Explain) _____            | <input type="checkbox"/> Medications _____   |

**Family History:**  Cancer  Diabetes  High Blood Pressure  
 Heart Problems/Stroke  Rheumatoid Arthritis

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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately 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 \_\_\_\_\_