Name:____ Date:______________________________

Address:_____________________________________City:__________________Zip:______________

Contact Phone: __________________________ Back up Phone: ___________________________

Date of Birth:_____________________ Age (_____) Referred By:_____________________________

Email:____Occupation:_________________________

Would you like to be added to our newsletter for office promotions and updates? _____yes ____no

Have you ever received chiropractic care before? ______yes ______no

Are you here for: chiropractic care______ nutrition response testing ______ Both_______

<u>About Your Health:</u>

Yes	No		Explain:
__	__	Did you play sports growing up?	__________________________________
__	__	Were you in any car accidents?	__________________________________
__	__	Were you hospitalized?	__________________________________
__	__	Any major traumas?	__________________________________
__	__	Any sports injuries?	__________________________________
__	__	Did/Do you smoke?	__________________________________
__	__	Did/Do you drink alcohol?	__________________________________
__	__	Do you have a healthy diet?	__________________________________

Nutrition:

How many servings of fruit do you have per day? ____________________________

How many servings of vegetables do you have per day? ____________________________

How many servings of meat do you have per day? ____________________________

How many servings of grain do you have per day? ____________________________

How much water do you have per day? ____________________________

How much caffeine do you have per day? ____________________________

How much pop do you have per day? ____________________________

Muscle Tension:

Do you normally have tight muscles? ____________________________

Do you carry your stress in your shoulders? ____________________________

Do you have more muscular pain after a stressful day of school? ____________________________

How many hours a day are you sitting? ____________________________

How often do you have headaches? ____________________________

Primary Reason for Consulting Office:

Present Complaint:____

When did this first begin?____

Describe the pain: ___Sharp ___Dull ___Constant ___Intermittent

Intensity now: please circle 1 2 3 4 5 6 7 8 9 10

Intensity at worst: please circle 1 2 3 4 5 6 7 8 9 10

Intensity at best: please circle 1 2 3 4 5 6 7 8 9 10

Is this condition worse in the: morning afternoon evening during sleep

Is this issue getting: worse better staying the same

Have you seen anyone for this issue?____

Are you using any home remedies?____

Other Symptoms:

___headaches	___pins and needles	___loss of smell
___neck pain/stiffness	___numbness in fingers/toes	___loss of taste
___sleeping problems	___shortness of breath	___diarrhea
___back pain	___fatigue	___hands/feet cold
___nervousness	___depression	___stomach upset
___tension	___light sensitivity	___constipation
___irritability	___loss of memory	___cold sweats
___chest pain	___ringing in ears	___loss of balance
___dizziness	___fever	___other symptom
___face flushed	___fainting	_________________

Final Details:

Have you been under medical care for this problem in the past?___________________________________

Are you on any prescription medication? Please list:____

Are you on any over the counter supplements?____

Have you had surgery and/or organs removed?____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	____________	_______	_______	_________	_______
Mother's Side	____________	_______	_______	_________	_______

Any other pertinent medical or health issues you would like us to know?

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Patient Signature:_______________________________________ Date:______________________________

Doctor Signature:_______________________________________ Date:______________________________