

PERSONAL HISTORY

DATE _____ NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAILING ADDRESS, IF DIFFERENT _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____

DOB ____/____/____ AGE ____ GENDER ____ HEIGHT _____ WEIGHT _____

SSN _____

OCCUPATION _____

YOUR EMPLOYER OR SCHOOL _____

EMPLOYER OR SCHOOL ADDRESS _____

IF MARRIED, SPOUSE'S NAME _____

SPOUSE'S SSN _____ SPOUSE'S DOB _____

IF A MINOR, PARENT'S NAME _____

PARENT'S SSN _____ PARENT'S EMPLOYER _____

ARE YOU PREGNANT? YES ____ NO ____

HOW DID YOU HEAR ABOUT THIS CLINIC? PHONE BOOK __ FRIEND __ TV __

RADIO __ NEWSPAPER __ OTHER _____

IN CASE OF EMERGENCY

CONTACT NAME _____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT PHONE NUMBER _____

PATIENT CONDITION

Present complaint _____

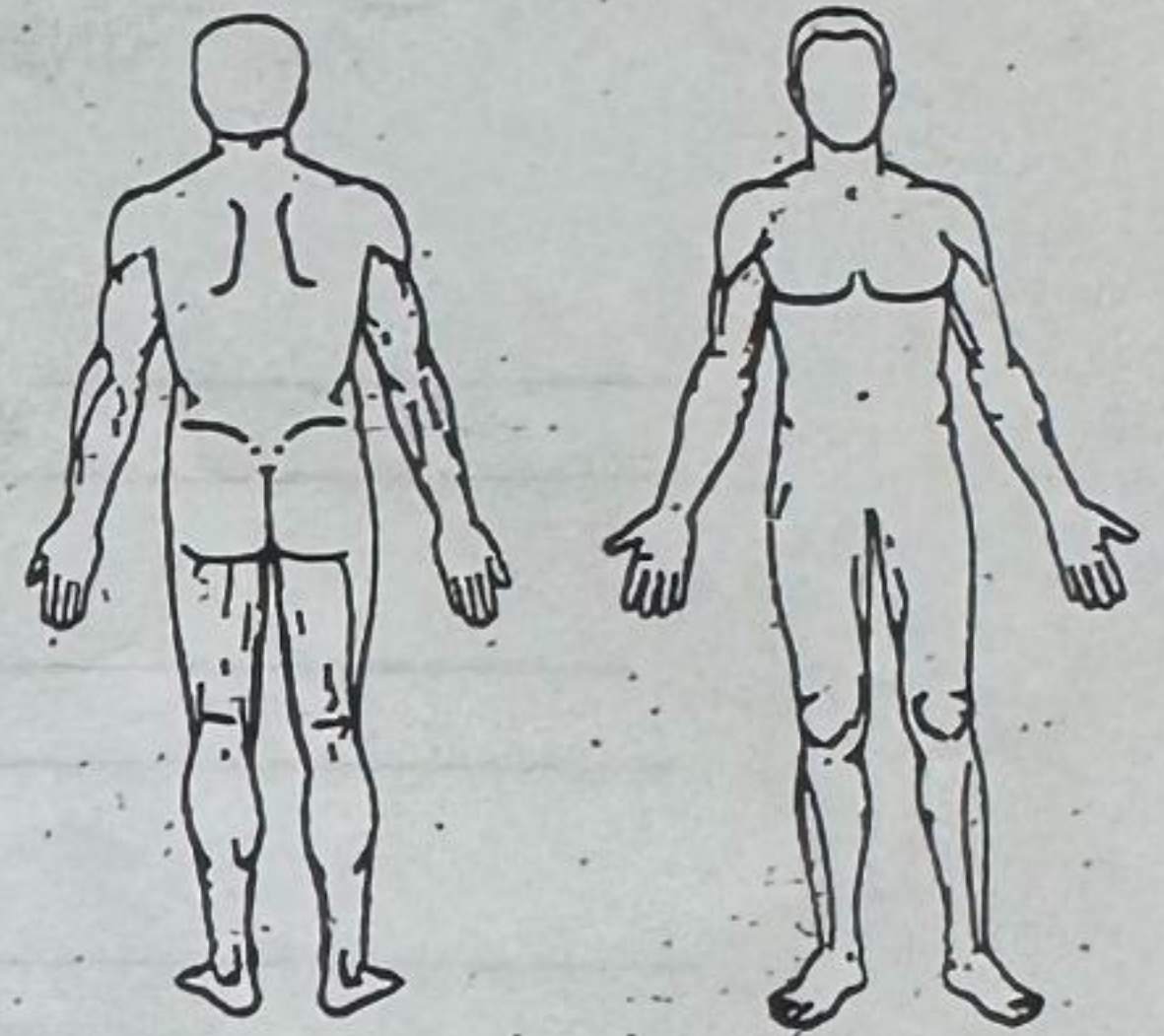
How did it start? _____

When did it start? _____
Mo Day Yr

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: () Sharp () Dull () Throbbing () Numbness
() Aching () Shooting () Burning () Tingling () Cramps
() Stiffness () Swelling () Other _____

Shade areas of discomfort



Does it interfere with () Work () Sleep
() Daily routine () Recreation

Activities or movements that are painful to perform
() Sitting () Standing () Walking () Bending () Lying down

Along with your present complaint, do you also periodically have
() Headaches () Neck pain () Mid back pain () Low back pain
() Numbness () Tingling or pain in arms or legs

If you have seen another chiropractic or medical physician within the last 12 months for this complaint, when? _____

Do you, or, have you had any tumors, bleeding disorders, diabetes, pacemaker, metallic implants, blood pressure problems, AIDS, ARC or heart problems? If so, please explain _____

List all previous surgeries _____

List all medications and for what conditions you are taking them _____

List all major accidents or injuries _____

Are you here for acupuncture? () Yes () No

By my signature below, I acknowledge that the above is true and accurate to the best of my knowledge.

Patient's Signature