



Straight Back Chiropractic  
2255 S. Broadway, Ste. 1  
Santa Maria, CA 93454  
(805)928-8866

## Patient Information:

Date	SSN	Birthday
First Name	Middle Name	Last Name
Sex Male      Female	Height	Weight
Married/Civil Union:	Spouse Name	# of Children
Home #	Cell #	Work #
Address		
City	State	Zip
Emergency Contact	Emergency Relation	Emergency Phone
Email		

## Referral Information:

Referring Physician:	Referred Patient:	Referred by
Advertisement:      Yes      No	Advertisement:	
Referred Directory:      Yes      No	Referred Directory:	

## Employer Information:

Employed:	Employer Name	
Employer Address:		
Employer City:	Employer State:	Employer Zip:
Occupation:	Work Supervisor:	Supervisor #:
Work Duties:		

## Reason for this Visit:

Describe the reason for this visit?

When did this concern begin?      Has this concern:      Gotten Worse      Stayed Constant      Come and Gone

Does this concern interfere with:      Work      Sleep      Daily Routine      Other Activities

Briefly Explain:

Has this concern occurred before?      Yes      No

Briefly Explain:

Have you seen other doctor's for this concern?      Yes      No      Doctor's name:

Type of Treatment:

## Health Checklist:

Alcoholism	Allergies	Anemia
Arteriosclerosis	Arthritis	Asthma
Autoimmune Disease	Back Pain	Bleeding Disorders
Breast Lump	Bronchitis	Bruise Easily
Cancer	Cataracts	Chest Pain
CHF	Cold Extremities	Constipation
COPD/emphysema	Cramps	CVA (stroke/TIA)
Dementia/Alzheimer's	Depression	Diabetes
Diagnosed emotional/mental	Digestion Problems	Dizziness
Epilepsy	Excessive Menstruation	Eye Pain or Difficulties
Fatigue	Frequent Urination	Gallbladder disease/stones
Glaucoma	Gout	Headache
Hemorrhoids	High Blood Pressure	Hot Flashes
Irregular Heart Beat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Liver disease/cirrhosis	Loss of Balance
Loss of Memory	Loss of Smell	Loss of Taste
Lung disease	Macular Degeneration	Migraines
Nosebleeds	Pacemaker	Parkinson's
Polio	Poor Posture	Prostate Trouble
Retinal Disease	Sciatica	Seizures
Shortness of Breath	Sinus Infection	Skin Sensitivity
Sleep Problems/Insomnia	Smoked	Spinal Curvatures
Stroke	Swelling of Ankles	Swollen Joints
Thyroid Condition	Tuberculosis	Ulcers
Varicose Veins	Venereal Disease	Other

Have you had any of these Cardiovascular Diseases? Please select all that apply.

Myocardial infarction	Hypertension	Hypercholesterolemia
Bypass surgery	Coronary artery disease	

Do you have Diabetes? If so what type?

Type I      Type II      Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

Ulcers	Reflux	IBS
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Signature

Date: