Today's Date:________________

First & Last Name: ____

Address:____

Home Phone:________________________ Work Phone:________________________

Cell Phone: ________________________ Date of Birth: ________________________

Male ____ Female____ Single____ Married____ Divorced____ Widowed____

Occupation: ____

Employer Name & Address:____

Spouse's Occupation: ____

Number of Children:________________ Referred By:________________________

CHILDHOOD YEARS

Did you have any childhood illnesses? ________________________________

Did you have any serious falls as a child? ________________________________

Did you play youth sports?________________________________

Did you have any surgery? ________________________________

Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree) __________

Were you involved in any car accidents?________________________________

Was there any prolonged use of medicine such as antibiotics or an inhaler? ____________

Did you suffer any other traumas? (physical or emotional) ____________________

Were you vaccinated? ____

As a child, were you under regular Chiropractic Care? ____________________

Comments:____

____

____

ADULT YEARS

Do/did you smoke? ____________________ Do/did you drink alcohol?______________

Have you been in any accidents? ________ Have you had any surgery? ____________

Do/did you play any adult sports? _______ Weight? ____________________________

On a scale from 1-10, describe your stress level: (1 = none, 10 = extreme)

Occupation: ____________Personal:___________

On a scale of Poor, Good, or Excellent, describe your:

	Poor	Good	Excellent
Diet:	____	____	____
Exercise:	____	____	____
Sleep:	____	____	____

General Health ____ ____ ____

ADDRESSING THE ISSUES THAT BRINGS YOU TO THE OFFICE

If you have no symptoms, and are here for wellness services, please check here:

____ **I wish to have Chiropractic Wellness Service**

(Please skip to "Family Health Profile" further below this form.)

Briefly describe the issue that brings you to the office, including the affect it has had on your life:

____

____

____

____

____

Other Doctors seen for this problem (please list):

Chiropractor: ____________________

Medical Doctor: ____________________

Other: ____________________

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

___Headaches	___Pins & Needles in Legs	___Numbness if Fingers	___Neck Pain
___Dizziness	___Pins & Needles in Arms	___Numbness in Toes	___Stiff Neck
___Fainting	___Loss of Balance	___Buzzing in Ears	___Back Pain
___Fatigue	___Loss of Smell	___Ringing in Ears	___Cold Hands
___Fever	___Loss of Taste	___Sleeping Problems	___Cold Feet
___Hot Flashes	___Menstrual Irregularity	___Upset Stomach	___Constipation
___Cold Sweats	___Menstrual Pain	___Ulcers	___Heartburn
___Sensitive Eyes	___Problem Urinating	___Nervousness	___Depression
___Tension	___Diarrhea	___Irritability	___Mood Swings

List any medications you are taking:

____

____

____

Family Health Profile:

Please mention below health conditions or concerns you may have about your:

Children: ____________________

Spouse: ____________________

Mother: ____________________

Father: ____________________

Brother(s): ____

Sister(s): ____

Others: ____

The statement on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature: ______________________________ Date: ______________

TERMS OF ACCEPTANCE

When one seeks chiropractic health care is accepted for such care, it is essential for both doctor and patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. The chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and spiritual well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Chiropractors do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, non – chiropractic or unusual findings are encountered, you will be advised.

Regardless of what the disease is called, chiropractors do not offer to treat it. Nor do chiropractors offer advice regarding treatment prescribed by others. The chiropractor's only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. The only method is specific adjusting to correct vertebral subluxations.

I, (print name) ____________________ have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: ______________________________ Date: ______________
(signature of parent or guardian if patient under 18 years old)