Please Print Clearly and fill In completely.

Print Name_____ **Email** _____

Street Address _____ **Phone**_____

City_____ **State** _____ **Zip** _____ **Date of Birth/Age** _____

Please Check ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑ Married❑ Single❑ Other❑

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, the conditions being treated for:

_____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name _____

Date of last chiropractic visit_____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care?_____

Are other family members under chiropractic care? - Yes❑ No❑ Who? _____

Wellness Commitment

At our office, we are dedicated to achieving the goal of total lasting health for our patients. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please ***circle*** *your personal level of commitment toward obtaining and maintaining health and wellness.*

10% ------- 20%-------- 30% --------40% --------50% ------- 60%-------- 70% --------80% --------90% ------- 100%

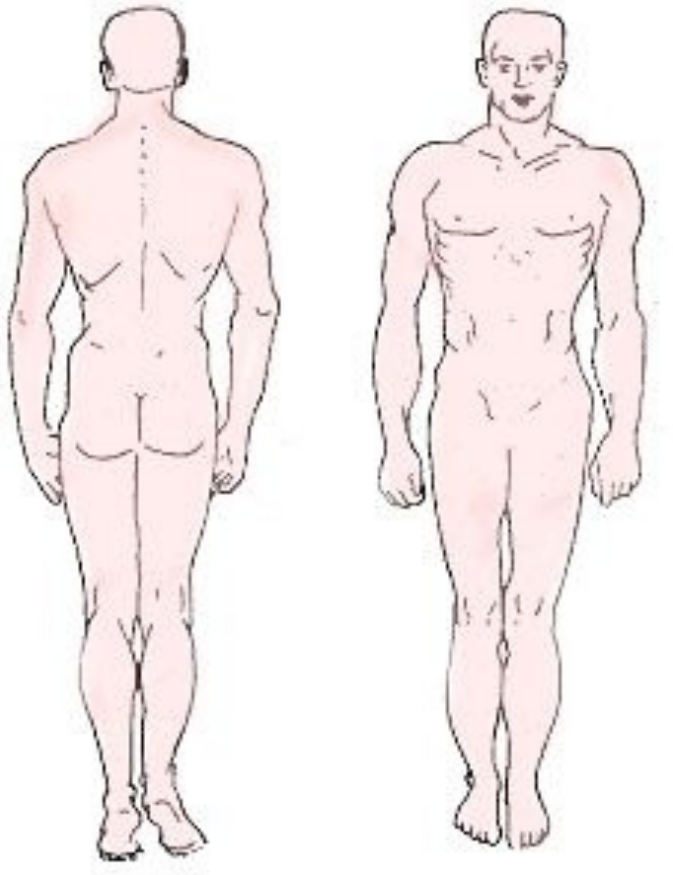
Where did you hear about us?_____
Who referred you? _____

FEMALES: *Please Check One* ✓ Is there a possibility of you being pregnant? Yes❑ No❑

Please Fill in Below: **If you have had the following, or if you suffer from the following,**
Please Check ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel is Important To Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____