



Name: _____ Age: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Home Telephone () _____ Work () _____ Cell () _____

Email Address: _____ Male _____ Female _____

Social Security # _____ Birth Date: _____

Occupation: _____

Employer Name and Address: _____

Single _____ Married _____ Spouse's Name _____

Have you seen a Chiropractor before? Yes No If yes, when? _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

List any medications you are taking _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

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

Patient Signature _____ Date _____

Guardian Signature _____ Date _____