

Date _____

File No: _____

Welcome! We Thank You for Your Trust!

Tell us about You.

1. NAME (LAST, FIRST, MIDDLE): _____	7. DATE OF BIRTH: _____
2. ADDRESS (STREET, CITY, STATE, ZIP): _____ _____ _____	8. NATIVE LANGUAGE: _____
3. TELEPHONE (INCLUDE E-MAIL OR FAX): _____ _____	9. HOW YOUNG ARE YOU? _____
4. EMPLOYER'S NAME AND ADDRESS: _____ _____ _____	10. SOCIAL SECURITY NO: _____
5. OCCUPATION: _____	11. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE
6. WORK PHONE: _____	12. SPOUSE'S NAME _____
	13. NUMBER OF CHILDREN: _____
	14. IS IT POSSIBLE YOU ARE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
	15. REFERRED BY: _____
	16. DO YOU HAVE HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO
	17. ARE YOU HERE DUE TO: <input type="checkbox"/> ON THE JOB INJURY <input type="checkbox"/> VEHICLE ACCIDENT <input type="checkbox"/> SLIP OR FALL <input type="checkbox"/> HEALTH PROBLEM <input type="checkbox"/> WELLNESS CARE
EMERGENCY CONTACT: NAME _____ RELATIONSHIP _____ PHONE _____	

Reason for Care.

1. WHY ARE YOU SEEKING CARE? _____
2. WHEN DID THE PROBLEM START? _____
3. HAVE YOU HAD THIS PROBLEM BEFORE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", WHEN: _____
4. IS THE PROBLEM (CHECK ALL THAT APPLY): <input type="checkbox"/> CONSTANT <input type="checkbox"/> INTERMITTENT <input type="checkbox"/> NUMBNESS <input type="checkbox"/> PINS AND NEEDLES <input type="checkbox"/> DULL ACHE <input type="checkbox"/> SHARP <input type="checkbox"/> BURNING <input type="checkbox"/> RADIATING <input type="checkbox"/> LOCALIZED <input type="checkbox"/> BETTER IN THE A.M. <input type="checkbox"/> BETTER IN THE P.M. <input type="checkbox"/> BETTER WHILE ACTIVE <input type="checkbox"/> BETTER WHILE SITTING <input type="checkbox"/> BETTER WHILE LAYING
5. DESCRIBE ANY OTHER HEALTH PROBLEMS: _____ _____
6. HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES" WHEN YOU WERE THERE LAST?: _____
7. LIST CURRENT MEDICATIONS: _____
8. LIST PAST SURGERIES AND DATES: _____
9. LIST PAST ACCIDENTS AND DATES: _____ _____

PLEASE SIGN: _____

DATE: _____

(Parent should sign for minor child)