Last Name:		**Date:**	
First Name:		Home No.:	
PO Box # or Mailing Addr		Cell No.:	
City, St, Zip:		Work No.:	
Occupation: Employer:		**Birth Date:** **Age:**	**Email:**
City, State:		**Gender:** Male Female	
Ins Policy #:		**Height:**	**Weight:**

Spouse's name and age:

Children's names and ages:

Favorite Hobbies and Interests:

Method of payment for todays visit: MC/Visa Check Cash

Whom may we thank for referring you to our office?

Why are you consulting our office today?

1

2

3

When did this condition begin?

What makes it better?

What makes it worse?

Is there pain associated with this condition? Yes No

What is the quality of the pain? Sharp Dull Ache Pins Needles Burning Other:

Is the pain local or does it radiate? Local Radiates

Where does the pain begin? End?

What time of day is it the worst? Morning After Work Evening Time:

What percent of the day does this bother you? 0 to 25 % 26 to 50 % 51 to 75 % 76 to 100 %

On the following scale, Please rate the condition:

Current: (1=least) 1 2 3 4 5 6 7 8 9 10 (10=worst)

At Worse: (1=least) 1 2 3 4 5 6 7 8 9 10 (10=worst)

How long does the pain last?

What doctors have you seen for this condition?

Have you ever been to a Chiropractor before? If so, whom?

Please list previous diseases and surgeries?

Please list medications and supplements?

Do you use a Tabacco product? Yes No What Kind?

For how long? How much?

Have you ever been diagnosed with Cancer? Yes No If so, what kind?

Has anyone in your family been diagnosed with Cancer? Yes No If so, whom & what kind?

Have you ever had or been diagnosed with a Disc Herniation? Yes No

If so, where? If so, when? Surgery? Yes No

Emergency Contact: Home #:

Relationship: Work #: