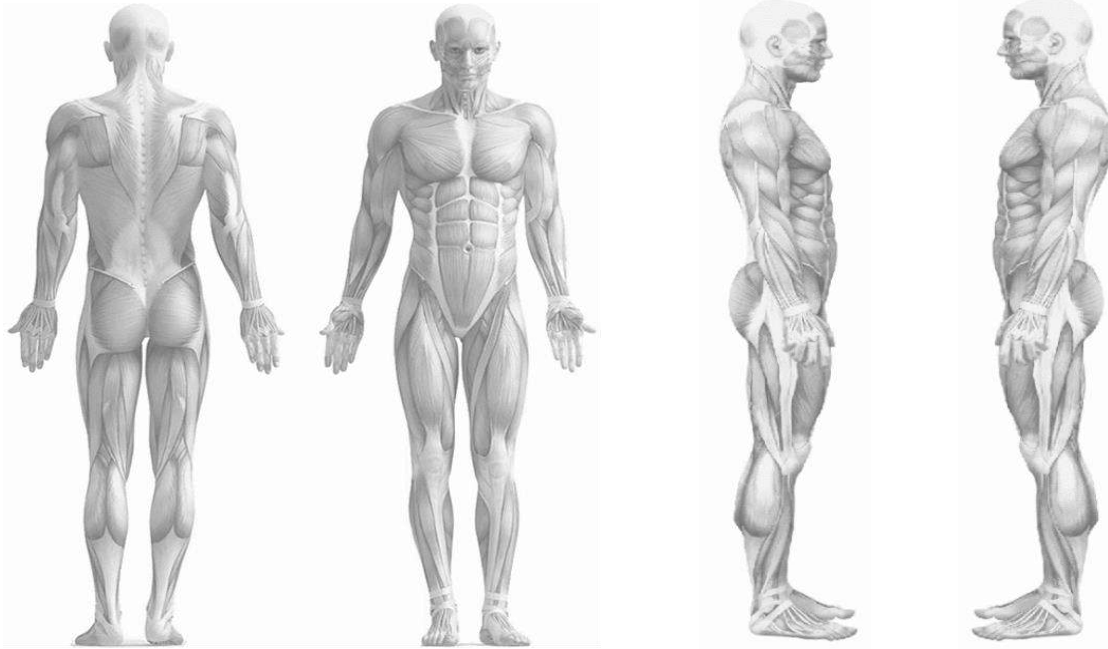


<b>Name</b>				<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DOB</b>	/	/
<b>Race/Ethnic</b>	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Black/African Amer	<input type="checkbox"/> Hispanic/Latin	<input type="checkbox"/> Native American	<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific/Hawaiian	
<b>Address</b>				<b>City</b>	<b>State</b>	<b>Zip</b>	
<b>Contact</b>	<b>Phone</b>			<b>Email</b>			
<b>Found us on</b>	<input type="checkbox"/> Google <input type="checkbox"/> Internet <input type="checkbox"/> Ad:		<input type="checkbox"/> Referral:		<input type="checkbox"/> Other:		
<b>Emergency Contact Name</b>				<b>Phone</b>	<b>Relation</b>		

**Please use the guide to mark your area(s) of complaints**



- A = Ache
- V = Sharp
- O = Throb
- T = Tight/Tension
- \* = Shooting
- S = Stabbing
- E = Electric
- B = Burning
- // = Tingling/Numb
- X = Other \_\_\_\_\_

**Please separate your complaints and describe them individually below. List most severe complaint first.**

Complaint # 1	Side/Location/Description	When did it start?	What caused it (if known)?

Complaint # 2	Side/Location/Description	When did it start?	What caused it (if known)?

Complaint # 3	Side/Location/Description	When did it start?	What caused it (if known)?

<b>Other Complaints</b>	<b>Description: Location of pain, How did it happen, Other relevant Information</b>

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### CURRENT MEDICAL HISTORY

Primary Care Doctor \_\_\_\_\_ Clinic \_\_\_\_\_ MD DO PA NP

Other Doctor \_\_\_\_\_ Clinic \_\_\_\_\_ Specialty \_\_\_\_\_

Other Doctor \_\_\_\_\_ Clinic \_\_\_\_\_ Specialty \_\_\_\_\_

Which of these Doctors are aware of your current complaint(s)? \_\_\_\_\_

Have you seen a Chiropractor before? \_\_\_\_\_

Current Meds <input type="checkbox"/> List provided	Allergies <input type="checkbox"/> List provided	Related Diagnoses/Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### PAST MEDICAL HISTORY

When was your last physical exam? Date \_\_\_\_\_ Doctor \_\_\_\_\_

#### Surgeries and Injuries

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### FAMILY HISTORY

CONDITION	Father	Mother	Sister	Brother	Grandfather	Grandmother
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list beside relative)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list beside relative)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list beside relative)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cause of Death If Deceased (Age at Death)					
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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SOCIAL HISTORY

**Employment:**  Full-time  Part-time  Student  Retired  Unemployed  Disabled  Other \_\_\_\_\_  
Occupation \_\_\_\_\_ Job Activities \_\_\_\_\_

**Cultural/Religious:** customs/beliefs we need to be aware of? \_\_\_\_\_

### Social / Health Habits:

- **Nicotine:**  Now  In Past  Tobacco  Smokeless  Vape How much? \_\_\_\_\_
- **Recreational Drugs:**  Now  In Past What Drugs? \_\_\_\_\_
- **Alcohol:**  Now  In Past  Alcoholic days/week \_\_\_\_\_ How much? \_\_\_\_\_
- **Caffeine:**  Coffee  Energy Drinks  Soda  Other \_\_\_\_\_ How much? \_\_\_\_\_
- **Exercise:**  Yes  No Type \_\_\_\_\_ days/week \_\_\_\_\_ minutes \_\_\_\_\_
- **Sleep Quality:**  Great  Good  Okay  Poor  Terrible Hours per night \_\_\_\_\_
- **Stress:**  Extreme  High  Moderate  Low  None

**General Health Status:**  Excellent  Good  Fair  Poor

**Living Environment:**  Alone  With Spouse  With Children  Other \_\_\_\_\_

**Language:** Primary \_\_\_\_\_ Other \_\_\_\_\_ Need a Translator?  Yes  No

**Disabilities:**  Vision  Hearing  Reading  Writing  Other \_\_\_\_\_

## REVIEW OF SYSTEMS

### Musculoskeletal

- Neck Pain
- Mid Back Pain
- Low Back Pain
- Shoulder/Arm Pain
- Hand/Wrist Pain
- Hip/Leg Pain
- Foot/Ankle Pain
- Jaw Pain
- Swollen Joints
- Stiff Joints
- Painful Joints
- Sore Muscles
- Weak Muscles

### EENT

- Vision Problems
- Eye Irritation
- Cataracts
- Eye Strain
- Ear Pain
- Hearing Problems
- Ringing in Ears
- Ear Discharge
- Sinus Pain
- Nose Pain
- Nose Bleeds
- Nose Discharge
- Difficulty Breathing
- Sore Throat

### Neurological

- Headaches/Migraines
- Numbness/Tingling
- Paralysis
- Dizziness/Vertigo
- Fainting
- Muscle Twitching
- Tremors
- Seizures
- Confusion
- Forgetfulness
- Depression
- Insomnia
- Balance/Walking Issues

### Gastrointestinal

- Poor Appetite
- Excessive Hunger
- Excessive Thirst
- Difficulty Chewing
- Difficulty Swallowing
- Blood in Stool
- Nausea
- Vomiting
- Stomach Cramps
- Diarrhea
- Constipation
- Bloating
- Gum Problems

### Constitutional

- Weight Gain/Loss
- Fever
- Fatigue

### Genitourinary

- Bladder Trouble
- Excessive Urination
- Scanty Urination
- Painful Urination
- Discolored Urine

### Cardiovascular/Pulmonary

- Chest Pain
- Difficulty Breathing
- Cough
- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Varicose Veins
- Swelling of Extremities

### Skin

- Rash
- Itching
- Color Change
- Strange Mole(s)
- Sores
- Blemishes
- Acne
- Nail Problems
- Hair loss
- Dry Skin

### Female Only

- Painful/Irregular Periods
- Vaginal Pain
- Vaginal Discharge
- Breast Pain
- Breast Lumps
- Pregnant
- Last Period \_\_\_\_\_

**I certify that the information provided on this form (3 pages) is true and complete to the best of my knowledge and authorize this office to evaluate, diagnose and treat my complaints based upon the information I have provided.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date