Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell

Social Security number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_

o I would like to receive a newsletter via email

Birth Date\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Male \_\_\_\_\_\_\_\_\_ Female \_

Occupation & Employer Name and Address,­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single Married Spouse's Name

Name of your Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 problems

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| □ Headaches  □ Pins and Needles in arms | D | □ Pins and needles in legs  □ Loss of smell | D | □ Fainting  □ Back Pain | D | □ Neck pain  □ Loss of balance  balance |
| □ Dizziness |  | □ Buzzing in ears |  | □ Ringing in ears |  | □ Nervousness |
| □ Numbness in fingers |  | □ Numbness in toes |  | □ Loss of taste |  | □ Upset stomach |
| □ Fatigue |  | □ Depression |  | □ Irritability |  | □ Tension |
| □ Sleeping Problems |  | □ Neck stiff |  | □ Cold hands |  | □ Cold feet |
| □ Diarrhea |  | □ Constipation |  | □ Fever |  | □ Hot flashes |
| □ Cold Sweats |  | □ Lights bother eyes |  | □ Problem urinating |  | □ Heartburn |
| □ Mood Swings |  | □ Menstrual Pain |  | □ Menstrual Irregularity |  | □ Ulcers |

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 examine me

for future evaluation.

Patient Signature Date \_ Guardian Signature Date \_