Welcome to Family Chiropractic

We are pleased to welcome you to our office. Please take a few minutes to fill this form out the best you can. If you have any questions we will be glad to help you. You have the right to leave any question unanswered.

Patient Information						
Name	Soc. Sec. #					
Address						
City	State	Zip Cell Phone				
Home Phone	Email					
Birthdate	Gender	Marital Status				
Race Are yo	u Hispanic or Latino?	Preferred Language				
Patient Employer		Occupation				
Whom may we thank fo	or referring you?					
Emergency Contact		Phone Number				
(P		e Information are <u>not</u> the Policy Holder)				
Insurance Policy Holder	name	Birthdate				
Relation to Patient		Phone				
Person Responsible Em	ployed by					
Insurance Company Na	me and Phone Numbe	r				
ID #		Group #				
	Reaso	n for Visit				
	Please circle all a	appropriate answers.				
Have you ever seen a c	hiropractor? Y or N I	f yes, when and why?				
What is the reason for	this visit? Please descri	be your pain and its location:				
Date symptoms began:	На	ave you had similar conditions in the past? Y or N				
How often do you have	this pain?					
Have you seen a medic	al physician for this cor	ndition? Y or N If yes, When?				

Movements that are difficult/painful to perform: Sitting Walking Bending Lifting
Type of pain (please circle): Sharp Throbbing Aching Burning Tingling
Numbness Cramping Stiffness Swelling Dull
Is pain interfering with: Work Sleep Daily Routine Recreation
On a scale of 1 to 10, 10 being the worst, how would you rate your pain?______
Health History
Do you have a Pacemaker? Yes or No

Are you pregnant? Yes or No If so, how far along?_____ Nursing? Yes or No Please list any prescriptions you are taking:_____

Please list any Vitamins or Supplements you are taking:

Please list any serious injuries and surgeries you have had within the last 10 years:______

Medical Conditions

Please circle if you have or had have any of the following medical conditions

Heart Attack	Jaw Pain	Emphysema	Gout	Headache
Congenital Heart Defect	Wrist Pain	Kidney Problems	Numbness	Ear Aches
Alcohol/Drug Abuse	Shoulder Pain	Artificial Bones	Tingling	Arthritis
Fainting/Seizures	Arm Pain	Artificial Joints	Cancer	Anemia
Shingles	Leg Pain	HIV+/AIDS	Muscle Spasm	Neck Pain
Psychiatric Problems	Back Pain	Ulcers	Diabetes	Dizziness

Personal Habits

Do you smoke? If yes, how much and how often?_____

Do you consume alcohol? If yes, how often?_____

Do you exercise? If yes, how often?_____