

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M / F  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Patient Primary Language \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Health Plan \_\_\_\_\_  
 Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Spouse Name \_\_\_\_\_  
 Spouse Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Care Physician Name \_\_\_\_\_ PCP Phone \_\_\_\_\_

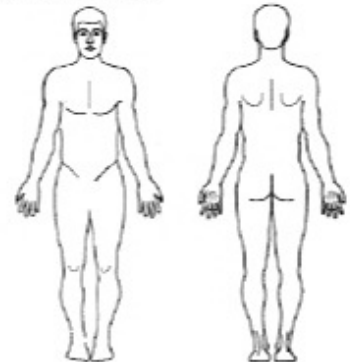
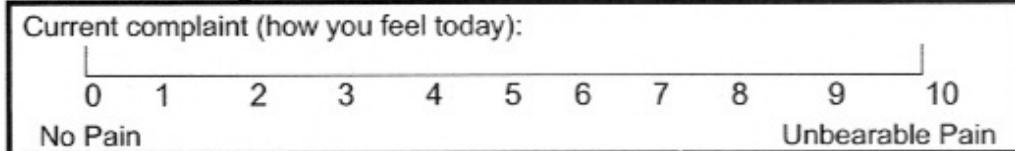
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

- Headache  Neck pain  Mid-back pain  Low back pain  
 Other \_\_\_\_\_  
 Is this?  Work Related  Auto Related  N/A

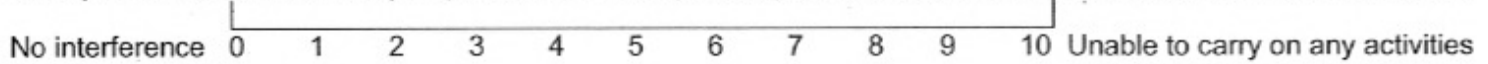
Date Problem Began \_\_\_\_\_

**How Problem Began**



How often are your symptoms present?  
 (Occasional)  0 – 25%  26 – 50%  51 – 75%  76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?**  No  Yes

Date(s) taken \_\_\_\_\_ What areas were taken? \_\_\_\_\_

**Please check all of the following that apply to you:**

- |   |  |
|---|--|
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> Stroke (date) _____                              | <input type="checkbox"/> Currently Pregnant, # weeks _____   |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills                       | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Pain Unrelieved by Position or Rest   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Pain at Night   |
| <input type="checkbox"/> Cancer/Tumor (explain) _____                     | <input type="checkbox"/> Visual Disturbances   |
| <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Surgeries _____   |
| <input type="checkbox"/> Epilepsy/Seizures                                | _____  |
| <input type="checkbox"/> Other Health Problems (explain) _____            | <input type="checkbox"/> Medications _____   |
| _____   | _____  |

**Family History:**  Cancer  Diabetes  High Blood Pressure  
 Heart Problems/Stroke  Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_