

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M / F  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Patient Primary Language: \_\_\_\_\_  
Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
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.

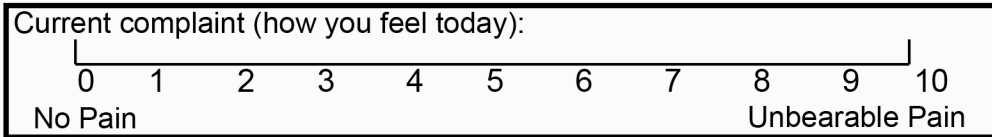
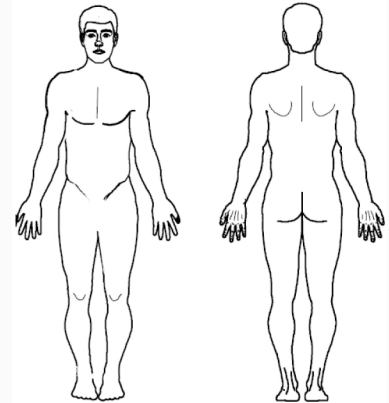
**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

- Headache  Neck pain  Mid-back pain  Low back pain  
 Other \_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

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

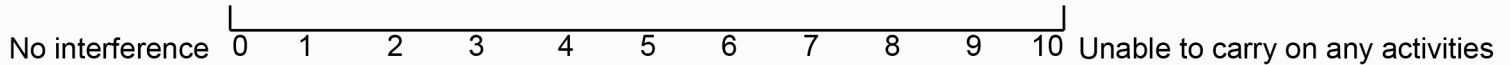
How Problem Began: \_\_\_\_\_



How often are your symptoms present?

- (Intermittent)  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"/> Surgeries _____   |
| <input type="checkbox"/> Osteoporosis                                     | _____  |
| <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: \_\_\_\_\_