PLEASE PRINT NECESSARY INFORMATION

AND

RETURN TO RECEPTIONIST - THANK YOU

NAME_____ _____

(First Name) (Last Name)

ADDRESS_____

(Number) (Street Name) (Postal Code)

PHONE NUMBER: Res:_____

Bus:_____

Cell:_____

BIRTHDATE:_____

(DAY) (MONTH) (YEAR)

MEDICARE NUMBERS:_____ _____

(6 Digit Number) (9 Digit Number)

OCCUPATION:_____

EMPLOYER:_____

MARITAL STATUS:_____ # of Dependant Children_____

HAVE YOU HAD CHIROPRACTIC CARE?_____ _____

(YES) (NO)

IF YOU HAVE HAD CHIROPRACTIC CARE - WHERE AND WHEN_____

_____

WHO REFERRED YOU TO THIS OFFICE:_____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ "**Wish to have Chiropractic Wellness Services**" and skip to "**Family Health Profile.**" Others need to briefly describe the chief area of complaint, including the affect it has had on your life.

_____

_____

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ☐ Comes & Goes ☐ Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Pins & Needles in Arms	☐ Loss of Smell	☐ Back Pain	☐ Loss of 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	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Sensitive Eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking _____

_____