

Name: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone: _____
How would prefer to be addressed? _____	Cell Phone: _____
Street: _____	Name of Insurance: _____
City: _____ Prov: _____ Postal Code _____	AHC #: _____
Birth date: Month: _____ Day: _____ Year: _____ Age: _____	Guardian contact: _____
Email: _____	Emergency Phone # _____
Occupation: _____	Relationship: _____

Reason for appointment: I have no complaints, I am here for a wellness check-up I have a specific concern

Indicate your primary condition (if applicable): _____

Is your condition due to an accident? No Yes Type of Accident: Auto Work Other

When did your condition begin? _____ **Have you had this condition before?** No Yes

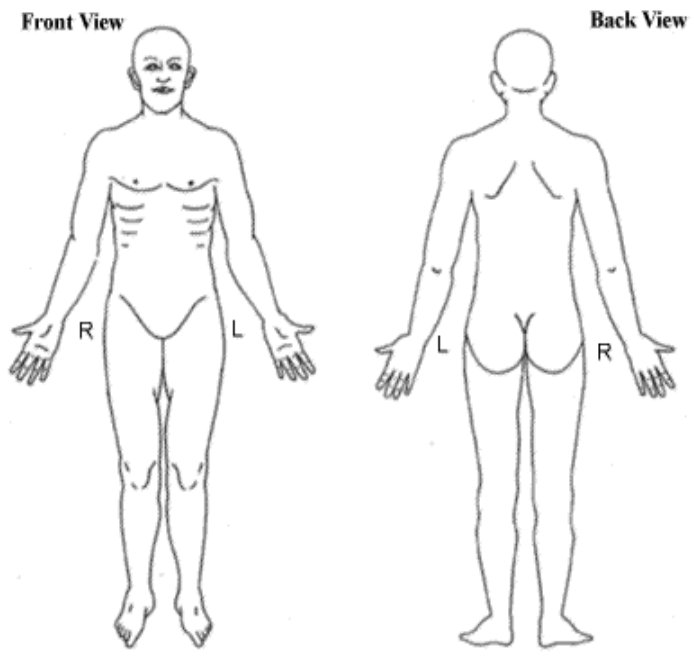
What caused your condition? _____

Have you had previous treatment for this condition? No Yes If so, specify what and when:

Have you had X-rays, MRI, or other tests for this condition? No Yes If so, specify what and when:

Does this condition interfere with your: work sleep personal life mood activities other

Describe: _____



Rate the intensity of your condition:
(least) 1 2 3 4 5 6 7 8 9 10 (worst)

What aggravates your condition?

What relieves your condition?

Indicate on the diagram:
S - for Sharp pain
D - for Dull pain / ache
N - for Numbness / tingling / burning

HEALTH HISTORY

Circle "C" for conditions you are currently experiencing or "P" for conditions you have had in the past.

Unexplained weight loss	C P	Slurred speech	C P	Poor concentration or memory	C P	Headaches	C P
Unrelenting pain (day and night)	C P	Previous stroke	C P	Frequent colds/infections	C P	Jaw pain	C P
Loss of bowel/bladder function	C P	Blurry/double vision	C P	Anxiety/depression	C P	Neck pain	C P
Fever/Chills/Sweats	C P	Heart palpitations	C P	Stomach pain	C P	Mid-back pain	C P
Poor appetite	C P	Fainting or dizziness	C P	Constipation/diarrhea	C P	Shoulder pain	C P
Pain over heart	C P	ringing in ears	C P	Heartburn	C P	Elbow pain	C P
Spitting up blood/phlegm	C P	High/Low blood pressure	C P	Poor digestion	C P	Wrist/hand pain	C P
Difficulty swallowing	C P	Difficulty sleeping	C P	Varicose veins	C P	Low back pain	C P
Nausea/vomiting	C P	Tremors	C P	Cold/swollen hands or feet	C P	Hip pain	C P
Blood in stool/urine	C P	Chronic cough	C P	Painful urination	C P	Ankle/Foot pain	C P
Difficulty breathing	C P	Ear infections	C P	Painful/irregular cycles	C P	Numbness/Tingling	C P

Indicate any secondary conditions concerning you: _____

Indicate all other health diagnoses: _____

Check all repetitive stressors you are currently experiencing:

Prolonged sitting	<input type="checkbox"/>	Desk / computer work	<input type="checkbox"/>	Repetitive lifting	<input type="checkbox"/>	Excessive driving	<input type="checkbox"/>
Prolonged standing	<input type="checkbox"/>	Poor posture	<input type="checkbox"/>	Repetitive sports/hobbies	<input type="checkbox"/>	Lack of sleep	<input type="checkbox"/>

Other repetitive stressors: _____

Have you had previous chiropractic care? No Yes

If so, Dr. _____ Clinic Name: _____ Date: _____

List all medications and supplements you are currently taking: _____

List all previous surgeries, illness, accidents and injuries: _____

Other relevant health information: _____

Teenage Females: Are you pregnant? No Yes Not Sure If yes: Due Date: _____

Legal Guardian signature: _____ Date: _____