SPORTS | ACTIVE | FAMILY
CHIROPRACTIC

Print Name ______________________ **Email** ______________________

Street Address ______________________ **Cellphone** ______________________

City ______________ **State** ______ **Zip** ________ **Date of Birth/Age** ______________

Please Check ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑ Married❑ Single❑

Health History:

Give reason for seeking chiropractic care: ______________________

____

Describe any health problems, including how long you've had them: ______________________

____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, the conditions being treated for:

____

List any current Medications: ______________________

List any past surgeries & dates: ______________________

List any past accidents & dates: ______________________

List any x-rays or other imaging you've had in the past 2 years: ______________________

Personal & Family History:

Your Occupation: ______________ Work Duties: ______________

Favorite physical activities: ______________________

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name ______________

Date of last chiropractic visit ______________ Reason for care ______________

How long were you under care? ______________ Preferred method of adjustment ______________

Do you have any specific questions you would like answered today?

____

____

How did you hear about our clinic: ______________________

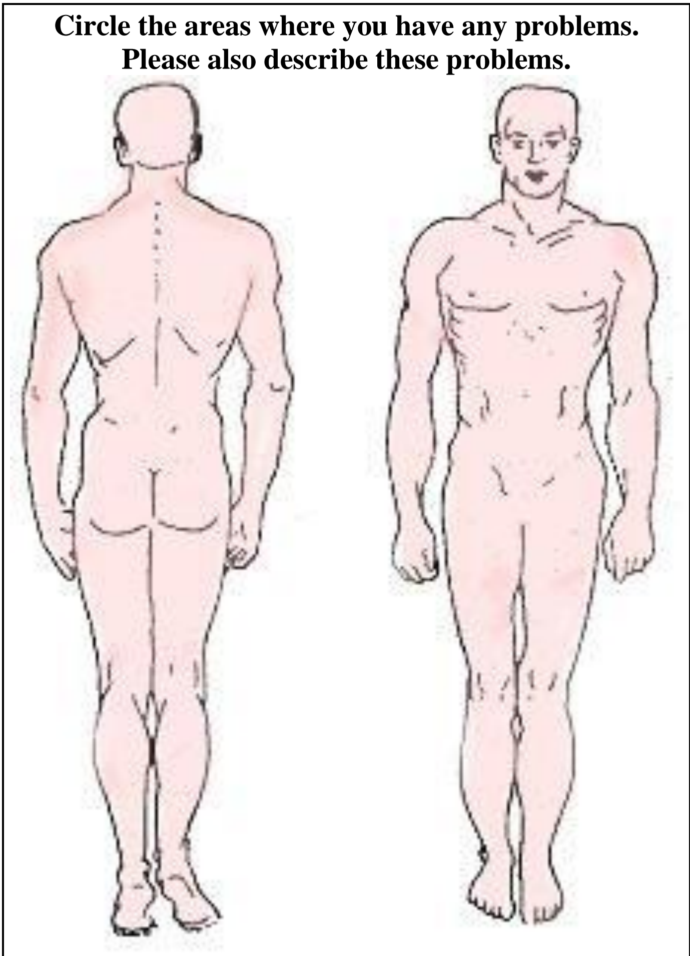
FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes❑** **No❑**

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	
Headache	❑
Migraines	❑
Neck Pain	❑
Shoulder Pain	❑
Arm/Hand Pain	❑
Mid Back Pain	❑
Low Back Pain	❑
Hip Pain	❑
Leg/Foot Pain	❑
Disc Problems	❑
Arthritis	❑
Other joint pain	❑
Numbness	❑
Joint Swelling	❑
Dizziness	❑
Nausea	❑
Weakness	❑
Fatigue	❑
Nervousness	❑
Insomnia	❑
Heart Problems	❑
Frequent colds	❑
Nose Bleeds	❑
Ringing in Ears	❑
Earaches	❑
Hearing Loss	❑
Cough	❑
Chest pains	❑
Female problems	❑
Allergies	❑
Asthma	❑
Cancer	❑
Osteoporosis	❑
Diabetes	❑
Hypoglycemia	❑
Digestive problem	❑
Urinary Problems	❑
Skin conditions	❑
Other __________	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

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Thank you for being complete and thorough.

Your Signature Below Please

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Date: ______________________________