Case No. _____

Last Name _____ First Name _____ Middle _____
Address _____ SS# _____ Birthdate _____ Age _____
City _____ State _____ Zip _____ DL# _____
Occupation _____ Spouse _____
Employer _____ Spouse's Occupation _____
# of Children _____ Phone _____ Work _____ Cell _____ Email _____
Contact in case of emergency _____ Referred By _____

What is your major complaint? _____
_____
_____
Other complaints?_____

How long have you had this condition?___ Have you had this or a similar condition in the past? ❑ Yes ❑ No
Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

___ Neck Problems
___ Shoulder Pain
___ Arm Problems
___ Numbness - Arms
___ Pain Between Shoulders
___ Low Back Problems
___ Leg Problems
___ Numbness - Legs
___ Loss of Feeling
___ Stiff Joints
___ Painful Joints
___ Restricts Daily Activities
___ Restricts Regular Exercise
___ High Blood Pressure
___ Dizziness

___ Sore Muscles
___ Walking Problems
___ Broken Bones
___ Muscle Cramps
___ Weak Muscles
___ Headaches
___ Fainting
___ Forgetfulness
___ Depression
___ Vision Problems
___ Ear Infections
___ Hearing Loss
___ Weak Muscles
___ Low Blood Pressure
___ Poor Digestion

___ Allergies
___ Hay Fever
___ Asthma
___ Exzema
___ Shingles
___ Nausea
___ Ulcers
___ Diarrhea
___ Constipation
___ Kidney Injection
___ Diabetes
___ Menstrual Cramps
___ Tiredness
___ Fatigue
___ Ear Pain / Noises

• This is a new / old illness. It was not / was treated before. If treated before, what was done. _____
_____

• Name of Doctors: _____

• Have you ever had surgery or been hospitalized?
❑ Yes ❑ No List Surgeries: _____
_____

• Have you ever had Chiropractic care before?
❑ Yes ❑ No
Name of Doctor: _____ Date: _____

• Last time you had spinal X-rays or other X-rays: _____

• Medications you now take: _____

• Female: Are you pregnant at this time?
❑ Yes ❑ No Due Date _____

From birth to present, please list by date / describe
1) Car accidents_____
_____
_____
2) Falls / Injuries (Including Sports) _____
_____
_____
3) Other_____
_____