

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

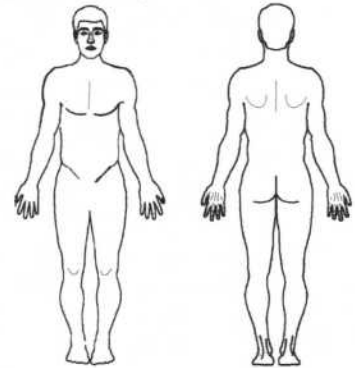
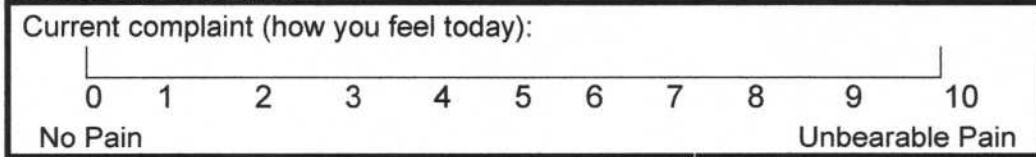
**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

Headache  Neck Pain  Mid-Back Pain  Low Back Pain  
 Other \_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

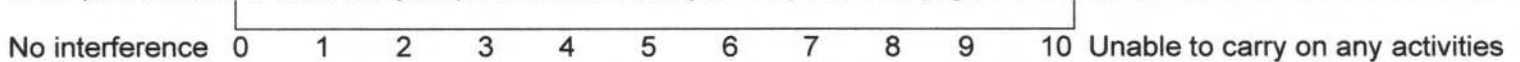
Date Problem Began \_\_\_\_\_

**How Problem Began**



How often are your symptoms present?  
(Occasional)  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:**

- Alcohol/Drug Dependence
- Recent Fever
- Diabetes
- High Blood Pressure
- Stroke (Date) \_\_\_\_\_
- Corticosteroid Use (Cortisone, Prednisone, etc.)
- Taking Birth Control Pills
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Cancer/Tumor (Explain) \_\_\_\_\_
- Prostate Problems
- Menstrual Problems
- Urinary Problems
- Currently Pregnant, # Weeks \_\_\_\_\_
- Abnormal Weight  Gain  Loss
- Marked Morning Pain/Stiffness
- Pain Unrelieved by Position or Rest
- Pain at Night
- Visual Disturbances
- Surgeries \_\_\_\_\_

- Osteoporosis
- Epilepsy/Seizures
- Other Health Problems (Explain) \_\_\_\_\_
- Tobacco Use - Type \_\_\_\_\_  
Frequency \_\_\_\_\_/Day
- 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** \_\_\_\_\_