



CHIROPRACTIC | NUTRITION | WEIGHT LOSS

Wellness Centers

Caring for you.

Caring about you.

Date: _____

Name _____ Age _____ Date of Birth ____/____/____
(First) (Middle) (Last)

Address _____
(Number) (Street) (City) (State & Zip)

Phone _____ Cell _____ Email _____

Social Security Number _____ Primary Doctor _____

Employer _____ Work Phone _____ Marital Status _____

Spouse's Name/Phone # _____

Insured Name (if different from above): _____ SSN _____ DOB _____

Guarantor (if different from above): _____ SSN _____ DOB _____

Address _____ Phone _____ Alternate Phone _____

Have you had previous chiropractic care? _____ Who referred you to this office? _____

Please list:

Any surgeries _____

Major accidents/falls _____

Family history (illness such as tuberculosis, diabetes, cancer, high blood pressure, etc. for yourself and immediate family) _____

FEMALE HISTORY: Date of last menstrual cycle _____ Regular _____ Irregular _____

Do you take birth control pills? _____ Are you pregnant? _____

Have you previously sought medical treatment for you complaints? _____

If yes, please explain _____

Doctors previously seen _____

Are your complaints related to an accident? _____ Yes _____ NO _____ Date of accident ____/____/____

If this is an accident or work related injury please ask the receptionist for additional forms.

Major Complaints: *(Be Specific)*

Name _____

- A) _____

- B) _____

- C) _____

- D) _____

- E) _____

- F) _____

Medications: _____

1. Which of your major complaints bother you the most (Check one or more) A B C D
2. How long have you had this complaint(s)? _____

3. Prior to the problem beginning, did you ever have an earlier problem that was the same or similar? _____

4. Did it appear Slowly Immediately?
5. Does anyone else in your family have this problem or a similar one? _____

6. How often does it bother you now? _____
7. When it is at its worst, how does it feel? _____
8. When it is at its worst, how does it interfere with your normal daily activities? _____

9. Does this problem reduce your productivity or effectiveness regarding your work? _____

10. Does it create any problems in your relationships? Yes No
If yes, how? _____
11. What helps this problem? What makes this problem worse? _____

12. If your problem was left unhandled for five years, how do you think it would affect you? _____

13. Are you committed to getting rid of not only your symptom(s) but what has caused it, even if it requires a change in your life-style? Yes No
14. (If children) Tell me about your children: _____

Auto Accident: _____

PI – Seatbelt Yes No Head Position Straight Ahead Rot. ()

MPH Impact _____ Amt. Damage to Vehicle _____ Ft. of Acceleration _____

Kind of Car – Theirs _____ Others _____ Position of Head Rest _____

Name: _____

Race (circle only one) American Indian Alaska Native
Asian White
Black or African American Native to Hawaiian
Other Pacific Islander Declined to State

Ethnicity (circle only one) Hispanic or Latino Not Hispanic or Latino
Declined to State

Smoking Status (circle only one) Current Every Day Smoker Smoking Start Date: _____ End Date: _____
Current Some Day Smoker
Former Smoker
Never Smoker

In effort to quit smoking, I am currently taking: _____

Do you have any allergies to medication? Yes No

If yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Are you currently taking any medication? Yes No

If yes, please indicate the following:

Medication: _____
Route: Oral
 Intravenous
 Other: _____

Frequency: _____
Began Use: _____
Discontinued use: _____

Medication: _____
Route: Oral
 Intravenous
 Other: _____

Frequency: _____
Began Use: _____
Discontinued use: _____

Medication: _____
Route: Oral
 Intravenous
 Other: _____

Frequency: _____
Began Use: _____
Discontinued use: _____

Medication: _____
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