

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Soc. Sec No. _____ Home Phone _____
 Address _____ City _____ Zip _____
 Age _____ Birth Date _____ HT _____ WT _____ Marital: M S W D How many children? _____
 Occupation _____ Employer _____
 Address _____ Office Phone _____
 Insured's name if patient is a dependent _____ Soc. Sec. No. _____
 Name of Insurance Company _____ Address _____
 Name of Wife or Husband _____ Occupation _____
 Employer _____ Address _____
 Patient's nearest relative _____ Address _____ Phone _____
 Referred by _____

Is condition due to injury or sickness arising out of patient's employment? Yes No

Date symptoms appeared or accident happened _____

Patient ever had same or similar condition? Yes No If yes, when and describe _____

Have you lost any days from work? _____

Date of last physical examination _____ Female: Are you pregnant? _____

What operations have you had _____

Serious illness _____

Have you ever been under Chiropractic Care Yes No Doctor's Name _____

Have you ever suffered from: P= Previously C= Currently

<p>P C</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness/Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p>Tingling or numbness in:</p> <p>P C P C</p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulders <input type="checkbox"/> <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> <input type="checkbox"/> Arms <input type="checkbox"/> <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> <input type="checkbox"/> Elbows <input type="checkbox"/> <input type="checkbox"/> Knees</p> <p><input type="checkbox"/> <input type="checkbox"/> Hands <input type="checkbox"/> <input type="checkbox"/> Feet</p>	<p>P C</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck pain or stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor posture</p> <p><input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> Spinal curvatures</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Colds</p> <p><input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> Ear noises</p> <p><input type="checkbox"/> <input type="checkbox"/> Enlarged Thyroid</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Falling vision</p>	<p>P C</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> Slow heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Pleurisy</p>	<p>P C</p> <p><input type="checkbox"/> <input type="checkbox"/> Spitting</p> <p><input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> <input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney infection or stone</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> Lumps in breast</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Polio</p> <p><input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p>
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HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

Do you now take vitamins or minerals? Yes No

Do you think you may need to take vitamins or minerals? Yes No

Are you wearing:
 Heel lifts Sole lifts Inner soles Arch supports