

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home phn \_\_\_\_\_ Cell phn \_\_\_\_\_  
Pager \_\_\_\_\_ E-mail Home: \_\_\_\_\_ E-mail Work: \_\_\_\_\_  
SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Male  Female  Single  Married  Divorced  # of children \_\_\_\_\_ Name of spouse (or parent) \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Wk phn \_\_\_\_\_ Occupation \_\_\_\_\_

What is the name of your family physician? \_\_\_\_\_ What city are they located in? \_\_\_\_\_  
Have you ever had Chiropractic care before? \_\_\_\_\_ If yes, doctor name: \_\_\_\_\_ Date of last visit \_\_\_\_\_  
If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity  
1. \_\_\_\_\_ For how long? \_\_\_\_\_  
2. \_\_\_\_\_ For how long? \_\_\_\_\_  
3. \_\_\_\_\_ For how long? \_\_\_\_\_  
4. \_\_\_\_\_ For how long? \_\_\_\_\_  
Has this problem been getting worse or staying the same? \_\_\_\_\_  
Currently or in the past have you ever experienced any of these complaints while working? \_\_\_\_\_ If yes, please describe what activities at work may be causing you to experience these complaints: \_\_\_\_\_  
Are there any other activities, incidents, or events outside of work that may have caused these complaints? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
Have you at any time in the past ever suffered a work injury? \_\_\_\_\_ If yes, what is the date of injury? \_\_\_\_\_  
Do you have an attorney representing you for this work injury? \_\_\_ Yes \_\_\_ No If yes, who is your attorney? \_\_\_\_\_  
Have you been involved in an auto accident in the last 12 months? \_\_\_ Yes \_\_\_ No If yes, what is the date of the auto accident? \_\_\_\_\_  
Do you have an attorney representing you for this auto accident? \_\_\_ Yes \_\_\_ No If yes, who is your attorney? \_\_\_\_\_  
How many other passengers were in the car with you? \_\_\_\_\_  
List other doctors consulted for these conditions: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
If due to an auto accident, what is the name of your auto insurance company? \_\_\_\_\_

Have you ever had any surgeries or hospitalizations? \_\_\_\_\_ If yes, please list: \_\_\_\_\_  
Please list any current or past injuries and illnesses not listed above: \_\_\_\_\_  
Please check all medications (over the counter and/or prescribed) you are currently taking:  Aspirin/Tylenol  Pain killers  Muscle Relaxers  
 Insulin  Birth Control Pills  Sleeping pills  Anti-Depressants  Others \_\_\_\_\_

Health Insurance Co. Name \_\_\_\_\_ Policyholder \_\_\_\_\_  
Name of Spouse's health insurance (If applicable) \_\_\_\_\_ Policyholder \_\_\_\_\_  
Spouse's Health Insurance Claims address \_\_\_\_\_ Policy number \_\_\_\_\_

