



"Your Health is Our Main Concern"

PT. # _____

Date: _____

Name		Nickname		Social Security No.	
Address & Street				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
City, State, Zip			Phone		Date of Birth Age
<input type="checkbox"/> Married <input type="checkbox"/> Widow	Health Ins. - Primary _____		Subscriber Name		Subscriber Date of Birth
<input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No	Secondary _____			
Subscriber Address			Subscriber Phone		
No. of Children	Ages	Cell Phone:		E-mail address	
Occupation	Employer			Work Phone No. ()	
Is your visit prompted by any specific complaints. Explain:				Preferred contact <input type="checkbox"/> work <input type="checkbox"/> home <input type="checkbox"/> cell	
Emergency Contact		Relationship		Phone ()	
Referred by		Have you had chiropractic care before? <input type="checkbox"/> Yes Where? <input type="checkbox"/> No		Do you have health insurance? <input type="checkbox"/> Yes Primary Company _____ <input type="checkbox"/> No Secondary Ins. _____	
Please indicate if you are here for care because of: <input type="checkbox"/> an on the job injury <input type="checkbox"/> an auto accident					

Have you ever had any falls, accidents or injuries? <input type="checkbox"/> Yes If needed use <input type="checkbox"/> No space below	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY		
Have you ever had surgery? <input type="checkbox"/> Yes If needed use <input type="checkbox"/> No space below	MONTH, YEAR	TYPE OF SURGERY	COMMENTS		
Are you presently taking medication? <input type="checkbox"/> Yes If needed use <input type="checkbox"/> No space below	NAME OF DRUG	DOSES PER DAY	NAME OF DRUG	DOSES PER DAY	
Is it possible you are pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prior Illnesses?			

Please check any of the following that give you difficulty.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Numbness in legs or feet |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Menstrual cramps and pain |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Grinding in neck | <input type="checkbox"/> Nerves and nervousness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Tightness of shoulders and arms | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Pain in shoulders and arms | <input type="checkbox"/> Irritability | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Pins and needles in arms & hands | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Ear ache | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in arms / hands | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cold hands / fingers | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Dizziness | | | <input type="checkbox"/> Pains in legs and feet |

Please indicate which activities of daily living are affected by your present complaints

General	<input type="checkbox"/> Walking	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Playing piano	<input type="checkbox"/> Using keyboard
	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Using a telephone	<input type="checkbox"/> Exercising
	<input type="checkbox"/> Climbing Stairs	<input type="checkbox"/> Lifting children	<input type="checkbox"/> Running	<input type="checkbox"/> Sitting in recliner
	<input type="checkbox"/> Chewing	<input type="checkbox"/> Reading	<input type="checkbox"/> Bending	<input type="checkbox"/> Getting into/out of an automobile
	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Swimming	<input type="checkbox"/> Lying in bed	
Housework	<input type="checkbox"/> Doing Laundry	<input type="checkbox"/> Vacuuming	<input type="checkbox"/> Ironing	<input type="checkbox"/> Caring for pets
	<input type="checkbox"/> Making beds	<input type="checkbox"/> Washing dishes	<input type="checkbox"/> Carrying groceries	<input type="checkbox"/> Cooking
Yardwork	<input type="checkbox"/> Mowing Lawn	<input type="checkbox"/> Raking leaves	<input type="checkbox"/> Gardening	<input type="checkbox"/> _____
Personal Grooming	<input type="checkbox"/> Combing hair	<input type="checkbox"/> Shaving	<input type="checkbox"/> In/out bathtub	<input type="checkbox"/> Brushing teeth
Travel	<input type="checkbox"/> Driving a car	<input type="checkbox"/> Riding in a car	<input type="checkbox"/> _____	<input type="checkbox"/> _____

NOTE: It is understood and agreed the amount paid Correct Care Chiropractic for x-rays is for examination only and the x-ray negatives will remain in the property of this office, being on file where they may be seen while a patient of this office.

Signature: _____ Date: _____

To avoid bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made.

Doctor's Use Only

P.O.P. / P.D. / P.S. (F.A.) / F.T. / L.O.T. / D.O.C. / H.P. / A.E.P. / N.L.W.

COMMENTS _____

SECONDARY COMPLAINT _____

A- 5/6/4 B- 3/5/4 C- 2/5/4 1/5/4 -C 0/2/5 -C _____ OTHER