**Email: How did you hear about us?**

**Phone:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | | | | | | | | | ❑ Mr.  ❑ Mrs.  ❑ Miss | | | Age:  Sex:  Birth date: | | | | Marital status (circle one) | | |
| First Name: | | | | | | | Middle: | | Single/Mar/Div/Widow | | |
| Address: | | | | | | | | | City: | | | | | | | State: | | Zip: |
| Occupation: | | | | | | | | | Children: Ages: | | | | | | |  | | |
| Medical Care Information | | | | | | | | | | | | | | | | | | |
| Do You Have a Family Doctor?  No  Yes, Name of Doctor: | | | | | | | | | | | | | | | | | | |
| Emergency Contact: | | | | | | | | | | Relation: Phone: | | | | | | | | |
| Do You Have a Family Chiropractor?  No  Yes, Name of Chiropractor: | | | | | | | | | | | | | | | | | | |
| Have you had surgeries in the last 5 Years:  Yes  No If yes, Last Surgery Date: | | | | | | | | | | | | | | | | | | |
| **Reason for Visit:** | | | | | | | | | | | | | | | | | | |
| Present illness /Conditions: | | | | | | | | | | |  | | | | | | | |
| AIDS | Cancer | | | | Heart Problem | | | | | | | | Multiple Sclerosis | | Spinal Disc Disease | | | |
| Allergies | Cirrhosis/hepatitis | | | | High blood pressure | | | | | | | | Pacemaker | | Thyroid trouble | | | Epilepsy |
| Anemia | Diabetes | | | | HIV/ARC | | | | | | | | Prostate trouble | | Tuberculosis | | | Neck |
| Arthritis | Dislocated joints | | | | Kidney trouble | | | | | | | | Rheumatic fever | | Ulcer | | | Low back |
| Asthma | Diverticulitis | | | | Low Blood Pressure | | | | | | | | Scoliosis | | Polio | | | Mid back |
| Bone fracture | Hay Fever | | | | Mental/ Emotional Difficulty | | | | | | | | Sinus trouble | | STD’S | | | Extremity |
| Other: | | | | | | | | | | | | | | | | | | |
| Family History of illness: | | | |  | | | | | | | | | | | | | | |
| AIDS | | Cancer | | | | Multiple Sclerosis | | | Spinal Disc Disease | | | | | STD’S | | |  | |
| Allergies | | Bone fracture | | | | Heart Problem | | | Low Blood Pressure | | | | | Sinus trouble | | | Ulcer | |
| Anemia | | Cirrhosis/hepatitis | | | | HIV/ARC | | | Mental/ Emotional Difficulty | | | | | Epilepsy | | | Polio | |
| Arthritis | | Diabetes | | | | High blood pressure | | | Prostate trouble | | | | | Thyroid trouble | | | Scoliosis | |
| Asthma | | Dislocated joints | | | | Kidney trouble | | | Rheumatic fever | | | | | Tuberculosis | | | Diverticulitus | |
| Other: | | | | | | | | | | | | | | | | | | |
| Type of Cancer: | | | | | | | | | | | Breast  Lung  Other: | | | | | | | |
| Social History: | | | | | | | | | | |  | | | | | | | |
| Alcohol?  No  Yes  Drinks per week? | | | Cigarettes?  No  Yes  Packs per day? | | | | | Caffeine?  No  Yes  Drinks per day? | | | | | | | | Exercise?  No  Yes Hours per week?  (circle one) Light / Moderate / Strenuous | | |
| Misc.: | | | | | | | | | | | | | | | | | | |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.