**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 [ ]  YesDrinks per week?  | Cigarettes? [ ]  No [ ]  YesPacks per day? | Caffeine? [ ]  No [ ]  YesDrinks 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.