Patient Name: ______________________ Date of Birth: ____________ Sex: M/F

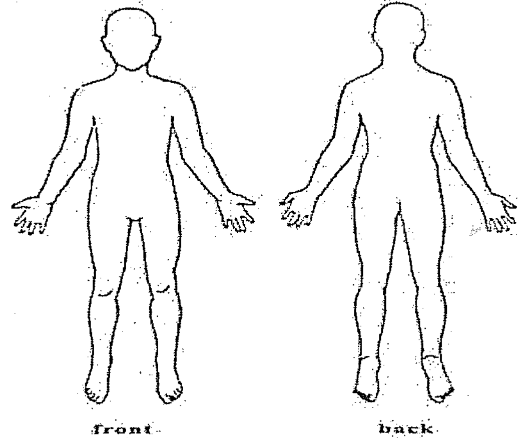
Address: ______________________ PCP: ______________________

Phone: ______________________ PCP Phone: ______________________

Email: ______________________ Occupation: ______________________

Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Social Security #: ____________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

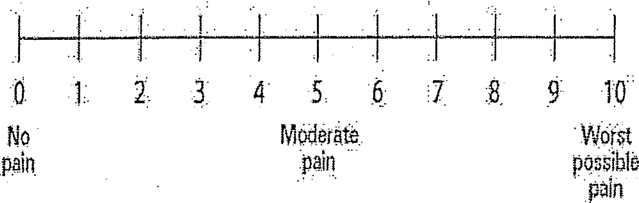
☐ Other: ______________________

Is this: ☐ Work-Related ☐ Auto Related ☐ N/A

Date Problem Began: ______________________

How Problem Began: ______________________

Current Complaint (How you feel today)



How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform daily activities? ☐ Yes ☐ No (Describe activity limitations) ____________

Have you had spinal X-rays, MRI, CT scan? ☐ No ☐ Yes

(Dates taken) ____________ What areas were taken? ____________

Please check all that apply: ☐ None Apply

☐ History of recent infection	☐ Aortic Aneurysm	☐ Neck Pain
☐ Recent Fever	☐ Cancer/Tumor	☐ Arthritis
☐ HIV/AIDS	☐ Osteoporosis	☐ History of Alcohol Use
☐ Diabetes	☐ Recent Trauma	☐ History of Tobacco Use
☐ Corticosteroid Use	☐ Prostate Problems	☐ Nocturnal Pain (Pain at night)
☐ Birth Control Pills	☐ Frequent Urination	☐ Surgeries____________ ____________
☐ High Blood Pressure	☐ Pregnant (# of Weeks: ___)	☐ Medications____________ ____________
☐ Stroke (Date:__________)	☐ Abnormal Weight Gain	
☐ Dizziness/Fainting	☐ Abnormal Weight Loss	
☐ Numbness in Groin/Buttocks	☐ Epilepsy/Seizures	
	☐ Visual Disturbances	
☐ Urinary Retention	☐ Low/Mid Back Pain	

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be comanaged. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: ______________________ Date: ______________