Patient Name: _____

Address: _____

Apt/Suite: _____ City: _____

State: _____ Zip Code: _____

Email: _____ @ _____ .com

Social Security #: _____ Home Ph: _____

Date of Birth: _____ Cell Ph: _____

Age: _____ Work Ph: _____

May we contact you by phone and leave a message? Yes or No

Employer: _____

Occupation: _____

Spouse's Name: _____

Spouse's Employer: _____ Work Ph: _____

Emergency Contact: _____

Emergency Contact #: _____

Who may we thank for referring you to our office?

Marital Status: Single Married Divorced Widow(er)

Race: White Black/African American American/Alaskan Indian
Patient Declined to Answer

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Preferred Language: English French Spanish Italian
Chinese Japanese Russian Portuguese

Present Complaint: What is the reason for your visit today? (Be Brief)

Area of major complaint: _____

Pain/Problem began on: _____

Pain(s) are: Dull Achy Sharp Stabbing Shooting Deep Throbbing

Pain(s) frequency is: Intermittent Occassional Frequent Constant

What activites lessen your condition? _____

What activites aggravate your condition? _____

Is your condition worse during certain times of day? _____

Is this condition interfering with Work? _____ Sleep? _____ Routine? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition? _____

Any home remedies? _____

**As a result of my chiropractic care, I would like to:**

Feel better quickly
Have a healthier body by keeping my nerve system healthy
Have a healthier spine
Live a healthier lifestyle

**I am here today for an evaluation and possible treatment for my condition listed above.**

_____ _____

Signature Date