

# PRENTICE CHIROPRACTIC



TODAY'S DATE \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: S M W No. Children \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

How did you hear about our office?  
\_\_\_\_\_

Were you injured on the job? No Yes When? \_\_\_\_\_

Were you injured in an auto accident? No Yes When? \_\_\_\_\_

Describe your present problem  
\_\_\_\_\_

Have you ever had this problem before? No Yes When? \_\_\_\_\_

When did the problem begin?  
\_\_\_\_\_

Other conditions:  
\_\_\_\_\_

Date of Last exam \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for seeking care? \_\_\_\_\_

What are your goals for care? \_\_\_\_\_

In general would you say your health is: Poor Fair Good Very Good

Please check the following habits (H = Heavy; M = Moderate; L = Light N = N/A) Circle One

Tobacco H M L N Alcohol H M L N Coffee H M L N

Drugs H M L N Overeating H M L N

Please indicate if you have a serious or chronic medical condition: (Circle all that apply)

- Neck Pain    Migraines    Asthma    Diabetes    Heart Disease    Cancer    Fatigue    Thyroid    Allergies  
Headaches    Dizziness    Arm Pain    Numbness    Chest Pain    Back Pain    Ulcers    Colitis    Sciatica  
Arthritis    Low Bld. Pressure    High Bld. Pressure    Gout    High Cholesterol    Anxiety/Depression    PTSD  
Joint Swelling    Freq. Urination    Constipation    Diarrhea    Sinus Problems    HIV Positive    Neck Tension  
Digestive Disorders    Nose Bleeds    Pain Between Shoulders    Anemia    Hot Flashes    Bursitis  
Crohn's Disease    Nervousness    Polio    Sleeping Problems    Goiter    Fertility Problems    IBS    ADD/ADHD

Please list any known food sensitivity or allergy:

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Other conditions, please specify:

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Any other health concerns?

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Prescriptions?

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Have you been treated for any health condition by a physician in the last year?    No    Yes

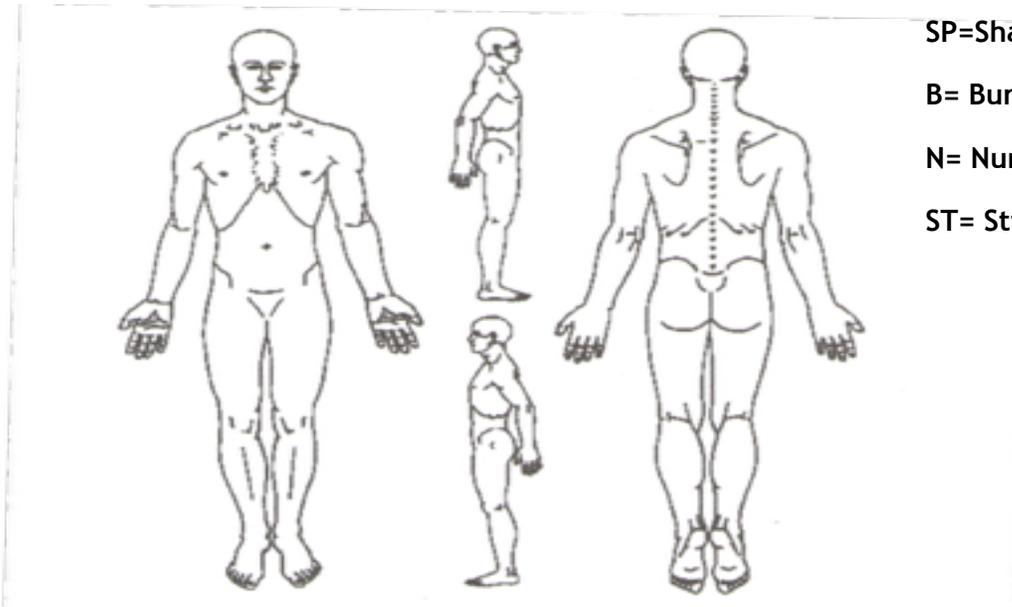
If so please describe:

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List your top 3 health complaints/concerns:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area using the abbreviations on the diagram below, along with a pain rating from the above scale.



**SP=Sharp Pain**

**DP= Dull Pain**

**B= Burning**

**S= Stinging**

**N= Numbness**

**T= Tingling**

**ST= Stiffness**

**A= Abnormal Sensation**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If patient is a minor.)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_