Patient Information

Name: _____ Birth Date: _____ Age: _____

Address: _____ Home Phone: _____ Mobile: _____

_____ Business Phone: _____ Pager: _____

_____ Number of Children: _____

Marital Status: ○ single ○ married ○ divorced Occupation: _____

Have you ever been treated by a chiropractor before? ○ Yes ○ No Name of chiropractor: _____

Were you referred to our office by someone? ○ Yes ○ No Who or What organization: _____

Have you had X-Rays before? ○ Yes ○ No When: _____ What part of the body? _____

Do you need an insurance receipt? ○ Yes ○ No E-mail: _____

Please list all medicines, herbs, and vitamins you are taking: _____

When was the last time you visited a dentist? _____

Do you currently have any dental problems? Please explain: _____

Please list all operations you have had with the dates: _____

Do you have any serious illness such as cancer, heart disease, kidney disease, liver disease, thyroid disease, asthma, digestive disease, high blood pressure or high cholesterol, diabetes, stroke?

Please list any condition you have: _____

Do any of your family members have a serious illness? _____

When was the last time you saw a medical doctor? _____

What was the purpose of your visit? _____

What is the main purpose of your visit Today? _____

What do you think is the cause of your problem? _____

How did your problem begin, slowly or suddenly? _____

Is your problem getting better, worse, or staying the same? _____

How long have you had your problem? _____

Have you had other treatment for your problem(s)? _____

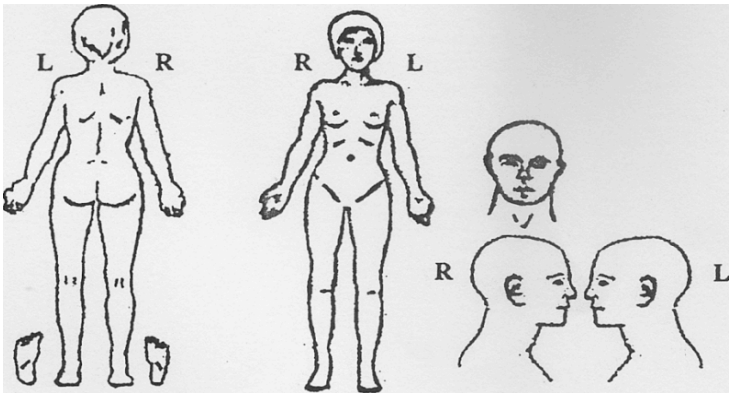
What have you done at home for your problem? _____

Are you interested in changing your diet if it would benefit your condition? _____

Have you had any accidents before? Please explain: _____

_____

Please mark the areas you have pain or numbness



Please check any additional symptoms you are having:

☐ Headache	☐ Hip Pain	☐ Numbness in Toes	☐ Face Flushed
☐ Neck Pain	☐ Knee Pain	☐ Shortness of Breath	☐ Ear Pain
☐ Neck Stiffness	☐ Chest Pain	☐ Fatigue	☐ Loss of Balance
☐ Sleeping Problem	☐ Head feels Heavy	☐ Depression	☐ Fainting
☐ Back Pain	☐ Pins and Needles in Arms	☐ Light bothers Eyes	☐ Dizziness
☐ Nervousness	☐ Pins and Needles in Legs	☐ Loss of Memory	☐ Irritability
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea
☐ Feet Cold	☐ Hands Cold	☐ Stomach upset	☐ Constipation
☐ Shoulder Pain	☐ Frequent colds	☐ Frequent Fevers	☐ Pain with Mestruation

Do you exercise on a regular basis? ○ Yes ○ No How often? _____

What kind of exercise? _____

Where do you exercise? _____

Do you sleep on ○ a hard mattress ○ soft mattress ○ the floor Other: _____

Do you sleep on ○ a high pillow ○ low pillow ○ more than one pillow? Other: _____

Is your pillow ○ soft ○ firm ○ foam ○ filled with filling? Do you use a contour pillow? ○ Yes ○ No

Do you spend a lot of time sitting at a desk or in traffic? _____

Do you drink alcoholic beverages? ○ Yes ○ No How many drinks a day? _____ a week? _____

How many drinks do you have at one time? _____

Do you smoke? How many cigarettes a day? _____ How many a week? _____

How many hours do you sleep a night? _____ Do you sleep well or poorly? _____

Do you have an excessive amount of stress in your life right now? ○ Yes ○ No

Do you go to for Thai massage? ○ Yes ○ No How often? _____

What kind of surface do you sleep on? _____