Patient Information

Today's Date: Day _____ /Month _____ / Year _____

Name: _____ Birthday: Day _____ /Month _____ / Year _____

Address: _____ Age: _____ Mobile: _____

_____ Line ID: _____

_____ Home Phone: _____

_____ Occupation: _____

E-mail: _____

Marital Status: ☐ single ☐ married ☐ divorced No. of Children: _____

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No How long ago?: _____

Were you referred to our office by someone? ☐ Yes ☐ No By who?: _____

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

What was the result? _____

Have you had an MRI before? ☐ Yes ☐ No When? : _____ What part of the body? _____

What was the result? _____

Do you need an insurance receipt? ☐ Yes ☐ No / Do you need a Medical Certificate? ☐ Yes ☐ No

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

_____

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

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

_____

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

_____

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? _____

How long have you had the problem you want looked at today? _____

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

Did your current problem begin, slowly or suddenly? _____

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

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

What have you done at home for your problem? _____

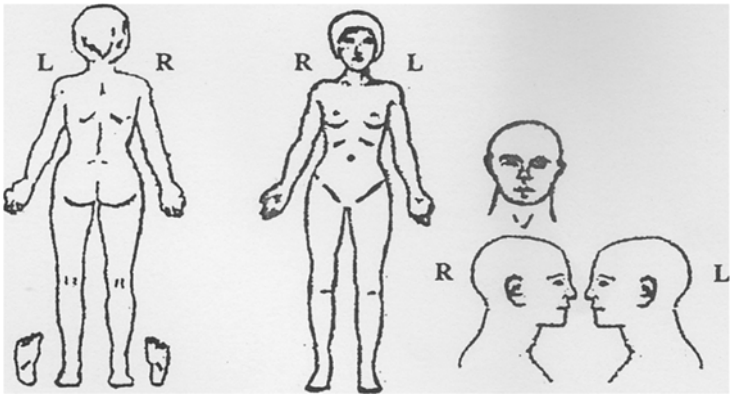
Have you had any accidents before? Please explain: _____

_____

When was the last time you visited a dentist? _____

Do you currently have any dental problems? 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? _____

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? _____