Name _____ DOB_____Date_____
Address _____City _____ Zip_____
Phone _____Cell _____Email_____
Referred by_____ Ins. Co. Name _____
Ins. Policy #_____ Group.# _____

What brings you in today? _____
_____
_____

When did it start? _____

How often is it occurring? _____

Describe the location and type of discomfort you are experiencing. _____
_____
_____

What makes it feel better/worse? _____
_____

Have you seen any other providers for this complaint? _____
_____

HISTORY

Have you had any major traumas (falls, car accidents, ect.) or surgeries? _____
_____
_____

Do you have any ongoing illnesses? _____
_____

Do you have any allergies, food sensitivities or eczema? _____
_____

What medications, vitamins or herbs are you taking? _____
_____

How often do you exercise? What do you do? _____
_____

Have you ever had chiropractic care before? When and with whom? _____
_____

Signature _____ Date _____