AddressCityStateZip	Name		•	:e//		Male/Female
Phone: Home						
Who may we thank for referring you?Email Address						
Single / Married / Divorced / Widowed Spouse's Name Number of Children Names, Ages & Gender Names, Names, Names, Ages & Gender Names,						
Single / Married / Divorced / Widowed Spouse's Name						
Number of Children Names, Ages & Gender BELOW Health Concerns: Rate of Severity this episode condition before, when? Did the problem symptoms begin with constant or an injury? Intermitten on the problem symptoms of the problem symptoms of the problem severity 1 = mild start? Discover, when? Did the problem symptoms of the problem of the problem symptoms of the problem of the probl						
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HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO CHIROPRACTOR?	·	Severity 1 = mild 10 = unbearable	this episode start?	condition before, when?	problem begin with an injury?	symptoms constant or intermittent
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	STROKE CANCER				NE SC	COLIOSIS DIABETI

LIST ALL SURGICAL OPER	RATIONS AND Y	YEARS			
LIST ALL Over the Count			ICATIONS YC	OU ARE ON:	
WHEN WAS YOUR LAST A					
HAVE YOU HAD PREVIOU	JS CHIROPRAC	TIC CARE?	YES / NO		
IF YOU HAVE, DR. & DAT	·E				
HAVE YOU EVER BEEN KI	NOCKED UNCO	NSCIOUS?	YES / NO	FRACTURED	A BONE? YES / NO
IF YES, PLEASE DESCRIBE					
OTHER TRAUMA:					
SOCIAL HISTORY 1. SMOKING: Digars Dipip 2. EXERCISE: How often? Displayed	☐ Daily ☐ Week	cends	casionally D	Never ATIONAL ACTIV	ITIES - EXERCISE
4. WHAT DAILY ACTIVITIES A	ARE BEING REST		OUR CURRENT		LEMS:
Sitting to Standing	Extended Comp	outer Use	Sweeping/Va	acuuming	Sleep
Climbing Stairs Pet Care	Garbage Lifting Children		Dressing Shaving		Static Sitting Static Standing
Yard Work	Walking		Bathing		Static Standing
Laundry	Dishes			\bigcirc	(••)
Other:				2	\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
*PLEASE MARK the areas on describe your symptoms: R = Radiating B = Burning S = Sharp/ Stabbing T = Tin What relieves your symptom What makes them feel wors	D = Dull A = Acongling	ching N = N u	ımbness		
				A	