Stevensville Chiropractic Center

Please Print Clearly and Fill in Completely

Name_____________________________ **Home Phone**_____________________________

Address_____________________________ **Work Phone**_____________________________

City, State, Zip_____________________________ **Cell Phone**_____________________________

Birth Date__________________ **Age**__________ **SS#**_____________________________

Occupation_____________________________ **Employer**_____________________________

Marital Status: M W Sep. D Sin. Spouse Name______________________ **No. of Children**________

E-mail Address____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name___________________________________

□ Telephone Call □ Yellow Pages □ Sign □ Website □ Presentation □ E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? ____________________________ **□ Never**

3. When was your last complete spinal examination including x-rays? ______________________ **□ Never**

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
□ Yes □ No ____

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? □ Yes □ No

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? □ Yes □ No

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Please list any health symptoms or health complaints you are experiencing.
1. ______________________ **2.** ______________________ **3.** ______________________

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?
____

11. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?
□ Yes □ No Date of Incident______________________

12. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant?
□ Yes □ No

13. Have you ever been diagnosed with cancer? □ Yes □ No

Type____ **Year**______________

14. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations?
□ Yes □ No

The above information is true and accurate to the best of my knowledge.

Patient Signature ___________________________________ **Date** ______________________

Please Like Us on Facebook @Stevensville Chiropractic Center

Reason For Visit

Reason for today's visit ____

____

____

□ **Emergency** □ **New Injury** □ **Old Injury** □ **Chronic Pain** □ **Wellness**

Are you in pain: □ **Yes** □ **No**

Rate your pain on the following scale: **Discomfort 1 2 3 4 5 6 7 8 9 10 Intense**

Did your injury occur during: □ **Work** □ **Sports/Play** □ **Auto Accident** □ **Routine/Household Activity**

When did you condition/accident occur? _____/_____/_____ **Where did your injury occur?**___________________________________

Is your condition getting worse? □ **Yes** □ **No** □ **Constant** □ **Comes and goes**

Is your condition interfering with your: □ **Work** □ **Sleep** **or** □ **Daily routine? If so, how:**________________________________

____

Has this or something similar happened in the past? □ **Yes** □ **No** **Explain:**____

____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition?

□ **Yes** □ **No** **If so, where?** _____________

____

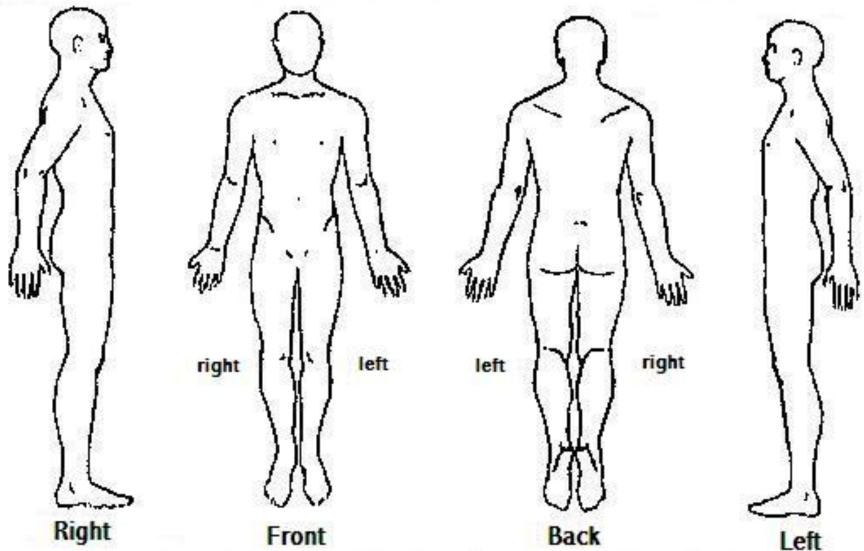
Have you ever been treated by a Chiropractor?

□ **Yes** □ **No**

Clinic or Dr's name:_______________________

____

Clinic phone # ___________________________



Health History

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke **Y N** Heart Surg. / Pacemaker **Y N** Heart Murmur **Y N** Congenital Heart Defect **Y N** Mitral Valve Prolapse
Y N Artificial Valves **Y N** Alcohol / Drug Abuse **Y N** Hepatitis **Y N** Venereal Disease **Y N** HIV + / AIDS / ARC
Y N Shingles **Y N** Frequent Neck Pain **Y N** Cancer **Y N** Glaucoma **Y N** Anemia / Diabetes
Y N High Blood Pressure **Y N** Psychiatric Problems **Y N** Sinus Problems **Y N** Rheumatic Fever **Y N** Severe / Frequent Headaches
Y N Ulcers / Colitis **Y N** Emphysema / Asthma **Y N** Tuberculosis **Y N** Difficulty Breathing **Y N** Lower Back Problems
Y N Chemotherapy **Y N** Kidney Problems **Y N** Fainting/Seizures/ Epilepsy **Y N** Artificial Bones/Joints/Implants **Y N** Arthritis

Please list any surgeries with dates and / or any other serious medical conditions not listed above:______________________________

____

List any past serious accidents with dates:____

Family Healthy History:____

Do you take Supplements or Vitamins? □ **Yes** □ **No** **Do you exercise?** □ **Yes** □ **No** _________ **hours per week**

Do you smoke? □ **No** □ **Yes** **How much?** ______________________________ **How long?** ___________________________________

Are you wearing: □ **Shoe lifts** □ **Inner soles** □ **Arch supports** **Are you dieting:** □ **No** □ **Yes** **Since:** ____/____/____