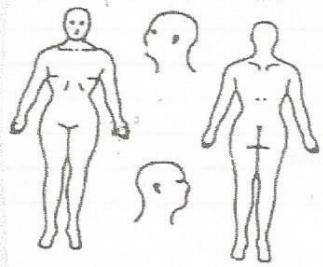
TOEWS CHIROPRACTIC P.C., 1225 N. Perkins Road Suite A, Stillwater, OK 74075, (405)372-3733

Name: Last: _____ First: _____ Middle: _____
Birthdate: _____ **Age:** _____ **Sex:** Male _____ Female _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: Cell: _____ **Home:** _____
Marital Status: Married: _____ Single: _____ Divorced: _____ Widowed: _____
Employer: _____ **Occupation:** _____
Insurance: _____ **ID#:** _____ **Group#:** _____

Mark area of complaint/symptom



Describe your complaints/symptoms: _____
Date complaints/symptoms began on: _____
Current level of pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain
What caused your complaints/symptoms: _____
Are there any radiating complaints/symptoms: No: _____ Yes: _____ If yes where: _____
Did your complaints/symptoms come on: Gradual: _____ Sudden: _____
Are your complaints/symptoms: Constant: ____ Frequent: ____ Occasional: ____ Intermittent: ____
Describe the character of your complaint/symptoms: Painful: ____ Soreness: ____ Stiffness: ____
Discomfort: ____ Sharp: ____ Dull: ____
Aching: ____ Numbness: ____ Burning: ____
Shooting: ____ Tingling: ____ Swelling: ____
What makes your complaints/symptoms worse: _____
What makes your complaints/symptoms better: _____
Does your complaints/symptoms interfere with: Work: ___ Sleep: ___ Daily activities: ___ Exercise: ___
Are you seeing another doctor: No: _____ Yes: _____
What treatment have your received: _____
Is this condition due to an accident: No: _____ Yes: _____ Type of accident: _____

Do you have any medical conditions, illnesses or diseases: No: _____ Yes: ____ If yes list: _____
_____
Are you taking medications: No: _____ Yes: _____ If yes list: _____
Do you have any allergies/drug allergies: No: _____ Yes: ____ If yes list: _____
Have you had any fractures/broken bones: No: _____ Yes: ____ If yes list: _____
Have you had any surgeries: No: _____ Yes: ____ If yes list: _____
Have you had any head injuries / concussions: No: _____ Yes: ____
Name of physician: _____
Name of chiropractor: _____
Name of surgeon: _____
Date of last physical exam: _____

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Do you exercise: No: ____ Yes: ____ If yes type of exercise: _____

Do you consume alcohol: No: ____ Yes: ____ Amount daily: _____

Do you consume coffee/caffeine drinks: No: ____ Yes: ____ Amount daily: _____

How much water do you drink daily: _____

Do you smoke: No: ____ Yes: ____

Do you use tobacco: No: ____ Yes: ____ If yes type of tobacco: _____

How many hours of sleep do you get each night: _____

What is your sleeping position: Back: ____ Side: ____ Stomach: ____

Do you have any musculo-skeletal problems: No: ____ Yes: ____ If yes list: _____

Do you have any cardio-vascular problems: No: ____ Yes: ____ If yes list: _____

Do you have any gastro-intestinal problems: No: ____ Yes: ____ If yes list: _____

Do you have any respiratory problems: No: ____ Yes: ____ If yes list: _____

Do you have any genito-urinary problems: No: ____ Yes: ____ If yes list: _____

Do you have any eye, ear, nose, throat problems: No: ____ Yes: ____ If yes list: _____

Do you have any skins problems: No: ____ Yes: ____ If yes list: _____

WOMEN: Are you pregnant: No: ____ Yes: ____

MEN: Do you have any prostate problems: No: ____ Yes: ____

Have you had any accidents or injuries: No: ____ Yes: ____

Is there a family history of any medical conditions, illnesses or diseases: No: ____ Yes: ____

Authorization:

I certify that I have read and understand the above to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any examination/evaluation and treatment rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners, I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if minor): _____ Date: _____