WELCOME

Member Information

Date:_____

Name: _____
Last First MI

Email Address: _____ Mailing Address: _____

Your Phone #:(H) _____ (C)_____ (W)_____
Contact Preference: *please circle your contact preference above*

Date of Birth: _____ Sex: ❑ Male ❑ Female SSN#: _____
Month Day Year

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Females: _____# Pregnancies *Pregnant or Nursing ____ Yes _____ No

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

Ethnicity: ❑ Hispanic ❑ Latino ❑Other: _____

Occupation:_____ # Hours working:_____Your Job Activities: _____

Your Hobbies:_____

How did you hear about our clinic? Patient___ Internet ___ Friend __ Phonebook __ Social Media __ Ad __Talk __ Other __

Emergency contact: Name: _____
Relation: _____ Phone #: _____

Who is your primary care physician? (doctor, specialty, city) _____
Are you receiving chiropractic care? Yes or No Doctor Name:_____ Last Adjustment:_____

Health History

Please check to indicate if you are *currently* experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	❑Other_____
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Of the above symptoms, what do you consider to be of the most concern to you? _____

Does this currently affect your:

☐ Mood	☐ Decision making	☐ Patience with spouse/children
☐ Irritability	☐ Attitude	☐ Ability to perform household duties
☐ Sleep	☐ Productivity	☐ Ability to exercise or participate in sports
☐ Daily activity performance	☐ Energy level	☐ Ability or desire to take part in hobbies
☐ Ability to work long hours		

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer*_____	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Gallbladder issues*	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Glaucoma	❑ Miscarriage	❑ Rheumatoid Diseases	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Weight History:

Please fill out if weight loss is a goal for you:

Why do you currently want to lose weight:_____
_____
How long have you struggled with your weight?_____
_____
Have you tried other weight loss plans and if so, what have you tried?_____
_____
What were you results?_____
_____
How long did you keep the weight off?_____
_____
How committed are you to weight loss and gaining your health: Not very 0 _____ 5 _____10 Totally

Other Health History:

Are you under drug or medical care? □ No □ Yes – Explain _____
_____
Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_____
_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____
_____
Please list any allergies (drugs, food, etc.): _____
Please list any supplements you are currently taking (**vitamins/herbs/minerals**): _____
_____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor
Exercise you do over & above work: ___ none ___ sedentary __ moderate __ heavy __ daily __ rarely __x week __ hours total

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/ day or week Tobacco_____ packs/day

LIST YOUR TEN MOST FAVORITE FOODS:
_____
_____

Do you or have you had a lot of stress in your life? __ no __ yes Rate the amount: None 0_____ 5 _____10 Severe
How often? __ daily __ less often Do you use a stress control technique? __yes __no
Under stress do you: ___ tend to eat ___ tend not to eat __ eat the same

Hours sleep each day: ___ Hours spend in bed each day: ___ Rate the quality of your sleep: Poor 0 _____5 _____10 Good
Global health scale: Rate your general well being: Poor 0 _____ 5 _____ 10 Good
Of all your health issues, which one would you most like to change/correct?

_____
What 2 or 3 things would you be able to do, or do better, if this one issue is fixed:
_____

How committed are you to regaining your health? Not very 0_____5_____10 Totally

In signing below, I acknowledge the information given is true and correct to the best of my knowledge.

_____ Date: _____
Signature (member or guardian)

Reviewed by:_____(Provider)