

Name (Last, first, m.):		Age:	Date of Birth ____ / ____ / ____
Address:		City, State, Zip	
Cell Phone:	Home Phone:	Work Phone:	
Email address:	Occupation:	Employer:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W	Children and ages:	
Closest Relation:		Phone:	
Who may we thank for your referral to this office?			

Your Health Profile

Please briefly describe the chief area of complaint, including the effect it has on you life.

My main complaint: _____

If you are experiencing pain is it: Sharp Dull Comes and goes Constant Burning Other

Since the problem began is it: About the same Getting worse Getting better Comes and goes

What makes it worse? _____

What makes it better? _____

It interferes with: Work Sleep Walking Sitting Standing Stairs Lifting Home life

I believe that the cause of my problem is: _____

I first noticed my problem: _____

Other doctors seen for this problem and what they did: Chiropractor _____
 Medical Doctor _____
 Other _____

Past Chiropractic care: When? _____ Who was your chiropractor? _____

Vitamins you take regularly and amounts: _____

Your stress history

Please indicate whether you have ever experienced stress in the following areas. Your answers will enable us to determine which experiences have contributed to your present health concerns.

Your Birth, Infancy and Childhood Years

<input type="checkbox"/> Difficult or Prolonged Labor	<input type="checkbox"/> Fall/Jump from height < 3 feet; age _____
<input type="checkbox"/> Breech position and/ or C-section	<input type="checkbox"/> Fall/Jump from height > 3 feet; age _____
<input type="checkbox"/> Drugs during labor	<input type="checkbox"/> Car accidents; age _____
<input type="checkbox"/> Forceps/ Vacuum extraction	<input type="checkbox"/> Beating, Child abuse
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Youth sports, which; age _____
<input type="checkbox"/> Repeated antibiotic use; age _____	<input type="checkbox"/> Head Trauma
<input type="checkbox"/> Childhood illnesses:	<input type="checkbox"/> Broken bones
<input type="checkbox"/> Prescription Medications	<input type="checkbox"/> Other Traumas
<input type="checkbox"/> Inhaler use	<input type="checkbox"/> Regular chiropractic health care throughout childhood

Adult (18 to present)

<input type="checkbox"/> Smoking	<input type="checkbox"/> Contact/ Extreme Sports
<input type="checkbox"/> Coffee Drinker	<input type="checkbox"/> Alcohol/ Drug Abuse
<input type="checkbox"/> Car Accidents; when	<input type="checkbox"/> Fall/ Jump from a height
First day of your last menstrual period ____ / ____ / ____	Could you possibly be pregnant? <input type="checkbox"/> Yes, <input type="checkbox"/> No
Your Height: _____	Your Weight: _____

Your Health History

Please check off all symptoms or conditions that you have experienced. Circle those symptoms that you currently are experiencing.

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies, Asthma | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Neck Pain/ Stiffness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness, Vertigo | <input type="checkbox"/> Numbness in hands and/or feet |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma/ Bronchitis | <input type="checkbox"/> Headaches, Migraines | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Sleep Problems/ Insomnia |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Immune System Disorders | <input type="checkbox"/> Stroke or TIAs |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Infertility | <input type="checkbox"/> Tingling (Pins and needles) in arms and/or legs |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> TMJ (Jaw) Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Menstrual Symptoms, Cramps | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Diarrhea, Constipation | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Are there any other health concerns that we should be aware of? No Yes _____

Are you pregnant or breastfeeding? Yes, No
 Do you have problems sleeping? Yes, No; Why? _____
 What position do you sleep in? Side, Back, Stomach
 Do you exercise regularly? Yes, No; If yes, what exercise do you enjoy? _____

List previous surgeries and dates
Medications (prescription and over the counter): <input type="checkbox"/> Pain Meds <input type="checkbox"/> Anti-inflammatories <input type="checkbox"/> Birth control <input type="checkbox"/> Heart Meds <input type="checkbox"/> Cholesterol Meds
<input type="checkbox"/> Antidepressants <input type="checkbox"/> Other _____ Prescribed by _____

Chiropractic Defined

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.

The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

I understand that the chiropractors in this office provide chiropractic adjustments to treat musculoskeletal complaints. I understand that all charges are due and payable at the time of service until I have provided insurance information that will cover all charges.

Signature _____/_____/_____
Date

I hereby give permission for Dr. Lundquist and Dr. Patterson to care for my minor child as they deem necessary.

Signature _____/_____/_____
Date

