

Health History

Name: _____ Birthday: _____ Age: _____ Today's Date: _____

Address: _____ City & State: _____ Zip: _____

Phone: _____ Email: _____

Social Security #: _____ Male ___ Female ___ Single ___ Married ___ Divorced ___

Occupation: _____ Employer: _____ Spouses Name: _____

Number of Children: _____ Whom may we thank for referring you to our office? _____

Have you seen a Chiropractor before? Yes No If Yes, when? _____

Your Health Summary

Past Current

- Headaches
- Pins & needles arms
- Dizziness
- Numbness in fingers
- Fatigue
- Sleeping problems
- Diarrhea
- Cold Sweats
- Mood swings
- Pins and needles legs
- Loss of smell/taste
- Buzzing in ears
- Numbness in toes
- Depression
- TMJ Disorder
- Migraines

Past Current

- Neck stiffness
- Constipation
- Light sensitivity
- Menstrual pain
- Menstrual irregularity
- Fainting
- Back pain
- Ringing in ears
- Irritability
- Cold Hands/Feet
- Fever
- Problems urinating
- Neck pain
- Loss of balance
- Nervousness
- Indigestion

Past Current

- Stomach Upset
- Tension
- Sports Injury
- Auto Accident
- Weight Trouble
- Heartburn
- Ulcers
- Anxiety
- Diabetes
- High Blood Pressure
- Hot Flashes
- Other: _____
- _____
- _____
- _____

List any medications you are taking: _____

On a scale of 1-10 with 10 being perfect health, my health today is a _____/10. I would like it to be a _____/10.

Informed Consent: All health interventions carry some degree of risk, as does lack of intervention. Chiropractic is no different. I understand these risks and give my doctor and the staff permission to proceed with diagnosis, treatment, and recommendations.

_____ (Please Initial)

Privacy: This office conforms to current HIPAA Guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate that you have been made aware of its availability:

_____ (Please Initial)