Name Date

Address: City State

ZIP

Phone: Home Cell Cell Provider Email Address: Date of Birth: / / Height: Weight: Age: Gender Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_

For the purposes of creating a safe space in our office, in what other ways do you self-identify that you’d like to specifically and explicitly let us know? \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: Employer’s Name: Single / Married / Widowed/ Partnered; Name:

Number of Children:

Names & Ages:

Who may we thank for referring you in?

EVAL COST:

**PLEASE LIST YOUR HEALTH CONCERNS BELOW**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health** | **Rate Severity** |  | **When did this** |  | **Did you have** | **Did the** | **Constant? or** |
| **Concerns:** | **1= Mild** |  | **episode start?** |  | **this condition** | **problem begin** | **Intermittent?** |
| **List Worst First** | **10=Unbearable** |  |  |  | **before? when?** | **with an injury?** |  |

 Since your problem started, is it

 ABOUT THE SAME GETTING BETTER GETTING WORSE

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What helps make it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you seen any other doctors for this condition?

 Chiropractor Medical Doctor Other

If so, WHO & WHEN: List Surgeries and Date

List all MEDICATIONS you are currently taking:

When was your last Auto Accident?

Have you ever been knocked unconscious? YES NO

Fractured any bones? YES NO If YES, Please describe: Any other bodily trauma?

**CIRCLE ANY & ALL OF THESE PROBLEMS YOU’VE HAD IN THE LAST 2 YEARS**

|  |  |  |  |
| --- | --- | --- | --- |
| DIZZINESS | ASTHMA | KIDNEY PROBLEMS | CHRONIC FATIGUE |
| HEADACHES | ULCERS | BLADDER PROBLEMS | LUPUS |
| VERTIGO | CHEST PAINS | IRRITABLE BLADDER | FYBROMYALGIA |
| EAR INFECTIONS | ARM NUMBNESS | SCIATICA | ADD / ADHD |
| GRATING OF NECK | ARM PAIN | LEG NUMBNESS | GERD |
| TMJ | HAND NUMBNESS | FEET NUMBNESS | ANXIETY  |
| NECK PAIN | SHOULDER PAIN | LOW BACK PAIN | NERVOUSNESS |
| MIGRAINES | HEART DISORDERS | HIP PAIN | EPILEPSY |
| STIFFNESS IN NECK | MID BACK PAIN | LEG PAINS | DISC PROBLEMS |
| CHRONIC SINUS | STOMACH DISORDERS | KNEE PAIN | INFERTILITY |
| THROAT ISSUES | NAUSEA or REFLUX | LIVER DISEASE | OTHER  |
| THYROID ISSUES | HIGH BLOOD PRESSURE | MENSTRUAL ISSUES |  |

**CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:**

STROKE - CANCER - HEART DISEASE - SPINAL SURGERY - SEIZURES - SPINAL FRACTURE - SCOLIOSIS – DIABETES

What are your expectations with care at The Source Chiropractic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_