

Name (First & Last): _____ Date: _____
 How did you hear about us? _____ Date of Birth: _____
 Occupation: _____ Employer: _____ Address: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Email: _____
 Emergency Contact Info: Name: _____ Relationship: _____ Phone: _____
 Who is your Medical Doctor? _____ Phone: _____
 Address _____ City: _____ State: _____ Zip: _____
 Do you have medical insurance? Yes No Would you like us to verify your insurance? Yes No
 Name of Insurance Company _____ Phone # _____
 Name of Insured _____ SS# _____ Date of Birth _____
 Insured's Employer _____
 Name of Insurance Company _____ Phone # _____
 Address _____ City _____ State _____ Zip _____
 Group # _____ ID # _____

Which areas carry the most tension? _____
 Have you ever had a professional massage before? YES NO
 Do you wear contact lenses? YES NO
 Do you have any known allergies? (ie. Food, nuts, or oils) _____
 Do you go to a chiropractor regularly? _____
 If so, Who? And How often? _____
 What are your chief complaints? _____
 Are you taking any prescribed or over the counter medication? YES NO
 If YES, please list and for what? _____

Please Mark the Intensity of Your Pain Today.
 1 - NO PAIN
 10 - MOST INTENSE EVER FELT
 Example Neck
 1 2 3 4 5 6 7 8 9 10
 1. _____
 2. _____
 3. _____
DOCTORS USE ONLY

Please mark area & type of pain on the drawings using the code listed below.

N - Numbness
 T - Tingling
 S - Sensation

P - Pain
 A - Ache
 ST - Stiffness



FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS

Smoking Packs/Day _____
 Drinking Alcohol _____
 Coffee Cups/Day _____

EXERCISE/SPORTS

None
 Moderate
 Daily
 Type: _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles	<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Venereal Infection
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Eczema	<input type="checkbox"/> HIV Positive

