

Name: _____ DOB: _____ Date: _____
Address: _____ Referral: _____
City: _____ State: _____ Zip: _____ Email: _____
Home phone: _____ Bus phone: _____ Fax: _____
 M F Height: _____ Weight: _____ Marital Status: S M D W Name of Spouse/Partner: _____
Children's Names & Ages: _____
Occupation: _____ Stress Level: Mild Moderate Extreme
What do you hope to receive from this office? _____

Is the reason you are consulting our office the result of an injury at work or an auto accident? Y N

Have you had your spine or nervous system examined professionally? Y N By whom? _____

What type of care was given? _____ Were you pleased? Y N

HISTORY OF PHYSICAL STRESSES

Birth Stress: Were there any problems associated with your mother's pregnancy with you? (check all that apply)

Falls/Injury Illness Difficult Comments: _____

Was your birth: (*check all that apply*) Traumatic C- Section Breech Forceps or suction Cord around neck

Prolonged Drug Induced Home Birthing Center Other Location

Comments: _____

General Physical Trauma: Falls: (check all that apply & age)

Crib/Carriage _____ Steps _____ On Ice _____ Out of Tree _____

Bars at school _____ Skating _____ Skiing _____ Snowboarding _____

Other Falls _____

Knocked unconscious _____ Used crutches/cane _____ Broken bones (which ones?) _____

Involved in combat _____ Physical fights _____ Physical abuse _____

Involved in sports _____ Extensive dental/orthodontial _____ Other _____

Accidents, near-accidents, driver or passenger: (check all that apply & age)

Automobile (how many and years) _____ Motorcycle _____ Bicycle _____

Bus _____ Train _____ Other _____

Comments: _____

Daily Activities: (*check all that apply*)

Sit Stand Walk Do desk work Phone work Wear contacts

Sports Exercise Watch TV Computer work Play musical instrument Wear glasses

Drive Read prolonged periods Mechanical work Heavy lifting Wear bifocals

Comments: _____

Medical Intervention (*Check all that apply & age*)

Hospitalization *why?* _____

Surgery *why?* _____

Chemotherapy _____ Radiation _____ Casts/collars _____ Spinal Neck Brace _____

Corrective shoes _____ Physical Therapy _____ Spinal tap/injections _____

X-Rays _____ Transfusion _____ Organ Removal _____

Comments: _____

Have you or your family suffered a serious illness? _____

Do you have a family doctor? Y N Who? _____

Date of last medical consultation & result? _____

For women: Are you pregnant? Y N Date of last monthly period: _____

How do you grade your physical health? Excellent Good Fair Poor Getting Better Getting Worse

Why? _____

