Case No. _____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ SS# _____ BIRTHDATE _____ AGE _____

CITY _____ STATE _____ ZIP _____ DL# _____

OCCUPATION _____ SPOUSE _____

EMPLOYER _____ SPOUSE'S OCCUPATION _____

OF CHILDREN _____ PHONE _____ WORK _____ CELL _____ EMAIL _____

Contact in case of emergency _____ REFERRED BY _____

What is your major complaint? _____

_____

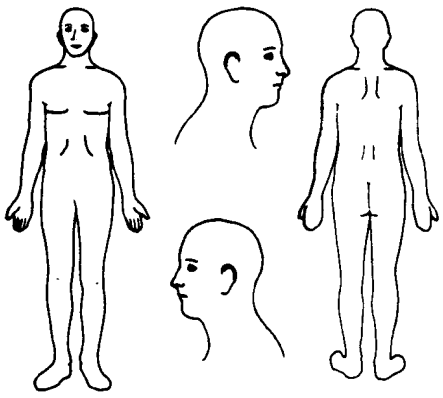
_____

Other complaints? _____

How long have you had this condition? _____ Have you had this or a similar condition in the past? _____

Is this condition getting progressively worse? Yes ❑ No ❑ Constant ❑ Comes and goes ❑

Please mark your areas of pain on the figures below.



_____ Neck Problems
_____ Shoulder Problems
_____ Arm Problems
_____ Numbness - Arms
_____ Pain Between Shoulders
_____ Low Back Problems
_____ Leg Problems
_____ Numbness - Legs
_____ Loss of Feeling
_____ Stiff Joints
_____ Painful Joints
_____ Restricts Daily Activities
_____ Restricts Regular Exercise

_____ Sore Muscles
_____ Walking Problems
_____ Broken Bones
_____ Muscle Cramps
_____ Weak Muscles
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Forgetfulness
_____ Depression
_____ Vision Problems
_____ Ear Pain / Noises
_____ Ear Infections
_____ Hearing Loss
_____ Frequent Colds

_____ Allergies
_____ Hay Fever
_____ Asthma
_____ Exzema
_____ Shingles
_____ Nausea
_____ Poor Digestion
_____ Ulcers
_____ Diarrhea
_____ Constipation
_____ Kidney Infection
_____ Menstrual Cramps
_____ Diabetes
_____ Blood Pressure
High / Low
_____ Tiredness / Fatigue

- This is a new / old illness. It was not / was treated before.
  If treated before, what was done? _____
- Name of Doctors: _____
- Have you ever had surgery or been hospitalized? ❑ Yes ❑ No
  List Surgeries: _____
- Have you ever had Chiropractic care before? ❑ Yes ❑ No
  Name of Doctor _____ Date _____
- Last time you had spinal X-rays or other X-rays: _____
- Medications you now take: _____

- Female: Are you pregnant at this time? ❑ Yes ❑ No Due Date _____

From birth to present please list by date / describe

1) Car Accidents _____

_____

_____

2) Falls / Injuries (Including Sports)

_____

_____

_____

3) Other _____

_____

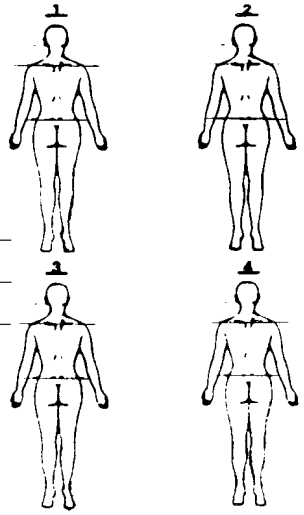
Sign & Date:

(FOR DOCTORS USE ONLY)

CERVICAL	Norm	Date 1	2	3	4
Flexion	50				
Extension	60				
Lat. R. Flex	45				
Lat. L. Flex	45				
Rotation Right	80				
Rotation Left	80				

LUMBAR	Norm	Date 1	2	3	4
Flexion	60				
Extension	25				
Lat. R. Flex	25				
Lat. L. Flex	25				
Rotation Right	30				
Rotation Left	30				

	1 L	1 R	2 L	2 R	3 L	3 R	4 L	4 R
F. Compression								
Shoulder Depression								
Kemps								
SLR								
Soto Hall								
Ely's								
Toe Walk								
Heel Walk								
Derefield Test								
Weight Distribution								
Dec. Int. Hip Rot.								
Dynanometer								



P _____

BP _____

T _____

Comments _____

_____

Height _____ Weight _____