FAMILY FIRST CHIROPRACTIC & WELLNESS CENTER

Date_____

Whom may we thank for referring you:_____

Last Name:_____ First:_____ SS#_____

Address:_____City:_____State:_____ Zip:_____ Date of Birth:_____Age:____

Email:_____Phone: Cell _____ Home_____

Emergency Contact: _____Phone:_____Married:☐ Yes ☐ No Spouse's Name:_____

Are you pregnant?☐ Yes ☐ No If so, how far along are you?_____ Due Date:_____

Occupation:_____Employer:_____May we contact you at work?☐ Yes ☐ No Phone:_____

Medical Doctor:
Doctor's Name:_____ Clinic Name:_____ Phone:_____

Healthcare Providers:
Doctor's Name:_____ Profession:_____ Phone:_____

Reason for Visit:
The reason(s) that have prompted you to seek care today:_____

_____

When did you first start noticing this?_____ How often does this occur? _____

Do you have any numbness or tingling? ☐ Yes ☐ No If so, where?: _____

Does the complaint travel? _____

Is this interfering with: ☐ Work ☐ Sleep ☐ Routine ☐ Other_____

Other Doctors seen for this reason?_____

What medications are you taking?_____

Have you had surgery? ☐ Yes ☐ No What?_____ When?_____

Check the quality of the complaint: ☐ Dull ☐ Sharp ☐ Aching ☐ Burning ☐ Nagging ☐ Throbbing ☐ Other

Grade the intensity/severity?

0 1 2 3 4 5 6 7 8 9 10
No pain — Need to go to the hospital

What relieves your symptoms? _____
What makes them feel worse? _____
Are your symptoms the result of ANY type of accident? _____
Please identify any other injuries to your spine that the doctor should know about: _____
Have you ever been diagnosed with a ☐ Bulging or ☐ Herniated disc?

Have you had a lumbar or cervical MRI in the last 7 years?☐ Yes ☐ No

MRI Clinic Name/Location: _____ MRI Clinic Phone Number: _____
Please identify the conditions that brought you to this office and how they happened: _____

_____

Do you have any other health concerns? _____

Past History:
Have you suffered with any of this or a similar condition in the past? _____
When was the last episode? _____ Have you ever been treated by anyone for this in the past? ☐ Yes ☐ No

When were you treated and by whom? _____

Please state the type of treatment and the results of the treatment: _____

Have you had any spine or disc surgeries? If yes, please describe: _____

How does this pain affect your daily activities? _____

Review of Symptoms: (Please mark all that are applicable.)

Neurological
- ☐ Allergies
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Nervousness
- ☐ Numbness
- ☐ Loss of Sleep
- ☐ Pins & Needles

Muscle & Joint
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot/Ankle Pain
- ☐ Hip Disorders
- ☐ Knee Pain
- ☐ Neck Pain
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ TMJ Disorder
- ☐ Low Back Pain

Skin
- ☐ Acne
- ☐ Dryness
- ☐ Eczema
- ☐ Rash
- ☐ Yeast/Fungus

Digestive
- ☐ Excessive Gas
- ☐ Colon Problems/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Gall Bladder/Liver Trouble
- ☐ Anorexia/Bulimia
- ☐ Ulcers

Respiratory
- ☐ Asthma
- ☐ Apnea
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Chronic Cough

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rapid Heartbeats
- ☐ High Cholesterol
- ☐ Pain Over Heart
- ☐ Poor Circulation
- ☐ Excessive Bruising
- ☐ Swelling of Ankles
- ☐ Abnormal Heartbeat
- ☐ Varicose Veins

Constitutional
- ☐ Fainting
- ☐ Fatigue
- ☐ Low Libido
- ☐ Poor Appetite
- ☐ Weakness

Genitourinary
- ☐ Bedwetting
- ☐ Infertility
- ☐ Kidney Infection
- ☐ Erectile Dysfunction
- ☐ Prostate Issues

Eyes, Ears, Nose & Throat
- ☐ Ear Infection
- ☐ Eye Infection
- ☐ Sore Throat
- ☐ Sinus Infection
- ☐ Tonsillitis
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Thyroid Problems

Female
- ☐ Heavy Flow
- ☐ Irregular Cycle
- ☐ Painful Cycle
- ☐ Discharge
- ☐ Menopausal (Yes / No)

Other

☐ Acid Reflux ☐ AIDS ☐ Anemia ☐ Alcoholism ☐ Arnold Chiari
☐ Autism ☐ ADHD ☐ Cancer ☐ Diabetes ☐ Epilepsy
☐ Fibromyalgia ☐ Gout ☐ Glaucoma ☐ Heart Disease ☐ Multiple Sclerosis
☐ Herniated Disc ☐ Hepatitis ☐ Migraines ☐ Spinal Degeneration ☐ Rheumatoid Arthritis
☐ Other_____

Family History

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Mother's Side	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

Social History:

Do you exercise regularly? ☐ Yes ☐ No
Do you drink? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
Do you take supplements? ☐ Yes ☐ No

YOUR GOALS FOR CARE:

☐ Feel better quickly/pain relief. ☐ Feel better and prevent its return.
☐ Have a healthier spine. ☐ I want optimum health and to live a healthier lifestyle.

We invite you to discuss with us any questions regarding our services. The best health services are based upon a friendly, mutual understanding between our team and yourself. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office.

Client's Signature_____ Date_____