



Today's Date

Name

Age

Date of Birth

Street Address

City

State

ZIP

Home Phone

Office Phone

Cellular Phone

Email

SSN

M F

Gender

Single Married Widowed Divorced

Marital Status

Number of Children

Spouse / Partner's Name

Referred by

Occupation

Internist / Physician's Name

Reason's for consulting our office:

Relief of symptoms Correction of a problem Wellness care for optimizing personal health

List your health concerns below in order of importance:

1. _____

What have you tried to solve this concern? _____

2. _____

What have you tried to solve this concern? _____

3. _____

What have you tried to solve this concern? _____



Have you ever been to a chiropractor? Yes No

If yes, what type of care did you receive? Pain Relief Correction Wellness

Do you / did you ever ... Smoke? Use Alcohol? (_____ Drinks per day)

Health History: Please check any of the following that are or have been part of your health picture.

- | | | | |
|---|--|--|--|
| Acid Reflux <input type="checkbox"/> | Depression <input type="checkbox"/> | Hernia <input type="checkbox"/> | Prostate Problems <input type="checkbox"/> |
| AIDS/HIV <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Herniated Disc <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/> |
| Alcoholism <input type="checkbox"/> | Drug Dependency <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> | Sinus Problems <input type="checkbox"/> |
| Allergies <input type="checkbox"/> | Eating Disorders <input type="checkbox"/> | Kidney Problems <input type="checkbox"/> | Sleeping Problems <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Emphysema <input type="checkbox"/> | Liver Problems <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Epilepsy/Seizures <input type="checkbox"/> | Loss of Balance <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Bleeding Disorders <input type="checkbox"/> | Excessive Fatigue <input type="checkbox"/> | Migraines/Headaches <input type="checkbox"/> | Tumors/Growths <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Fractures <input type="checkbox"/> | Miscarriage <input type="checkbox"/> | Ulcers <input type="checkbox"/> |
| Chronic Irritability <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Numbness <input type="checkbox"/> | Urinary Problems <input type="checkbox"/> |
| Concussion <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | |

Psychiatric Care, Hospitalizations, and Surgeries:

Women:

Are you pregnant? Yes No Nursing? Yes No On birth control? Yes No

Menstrual History:

Age at onset: _____ Usual period duration: _____ days Cycle (start-start): _____ days

Date of last period: _____ Are you regular? Yes No Flow: heavy medium light

Do you have: Tension Depression Before Period Cramps Pain with Period

Pregnancies:

Yes No Complications? _____



What are your health goals and expectations? _____

When was the last time you felt your best (how long ago)? _____

On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in loss of health potential. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your potential for better health.

List all surgeries and their approximate date. _____

List all medications you are currently taking. _____

List any significant physical trauma from birth to present. _____

List any emotional trauma from birth to present. _____

On a scale of 1 to 10, (1 = no stress, 10 = extreme stress) how stressful is ...

your occupational life? _____ your personal life? _____

What do you feel is your primary cause of stress? _____

I certify that I have read and answered accurately all of the above questions. I authorize Madison Square Chiropractic & Wellness to release any information to any third party payer and/or any licensed health care practitioner regarding my care, otherwise payable to me. In the event that the insurance company fails to make payment for services rendered, such payments are ultimately the responsibility of the patient.

Signature of Patient

Signature of Guardian if a minor

Date