



THE SOURCE
CHIROPRACTIC

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ Cell Provider: _____

Email Address: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ Age: _____ Gender Pronoun: _____

For the purposes of creating a safe space in our office, in what other ways do you self-identify that you'd like to specifically and explicitly let us know? _____

Occupation: _____ Employer's Name: _____

Active Military/Veteran: ____ YES ____ NO – Which branch/years: _____

Single / Married / Widowed /Life Partnered – Name: _____

Pregnant? ____ YES ____ NO Number of Children: _____ Names & Ages: _____

Who may we thank for referring you in? -- _____

Emergency Contact: _____ Relationship: _____ Phone: _____

PLEASE LIST YOUR HEALTH CONCERNS

Health Concerns: List Main Concern First	Rate Severity 1= Mild 10= Unbearable	When did this episode start?	Did you have this condition before? When?	Did the problem begin with an injury?	Constant? Intermittent?

Since these complaints/concerns started, are they:
____ ABOUT THE SAME ____ GETTING BETTER ____ GETTING WORSE

What makes it worse? _____

What makes it better? _____

What are these concerns keeping you from doing? _____

Have you seen any other doctors/ health providers for this condition?

_____ Chiropractor _____ Medical Doctor _____ Other

If so, WHO & WHEN: _____

List SURGERIES (if any) and dates: _____

List all MEDICATIONS you are currently taking: _____

When was your last Auto Accident? _____

Have you ever been knocked unconscious? _____ YES _____ NO

Fractured any bones? _____ YES _____ NO – If YES, please describe: _____

Any other bodily trauma: _____

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

- | | | | |
|-------------------|---------------------|-------------------|-----------------|
| DIZZINESS | ASTHMA | KIDNEY PROBLEMS | CHRONIC FATIGUE |
| HEADACHES | ULCERS | BLADDER PROBLEMS | LUPUS |
| VERTIGO | CHEST PAINS | IRRITABLE BLADDER | FYBROMYALGIA |
| EAR INFECTIONS | ARM NUMBNESS | SCIATICA | ADD / ADHD |
| ALLERGIES | ARM PAIN | LEG NUMBNESS | GERD |
| TMJ | HAND NUMBNESS | FEET NUMBNESS | ANXIETY |
| NECK PAIN | SHOULDER PAIN | LOW BACK PAIN | NERVOUSNESS |
| MIGRAINES | HEART DISORDERS | HIP PAIN | EPILEPSY |
| STIFFNESS IN NECK | MID BACK PAIN | LEG PAINS | DISC PROBLEMS |
| CHRONIC SINUS | STOMACH DISORDERS | KNEE PAIN | INFERTILITY |
| THROAT ISSUES | NAUSEA or REFLUX | LIVER DISEASE | OTHER |
| THYROID ISSUES | HIGH BLOOD PRESSURE | MENSTRUAL ISSUES | |

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE - CANCER - HEART DISEASE - SPINAL SURGERY - SEIZURES - SPINAL FRACTURE - SCOLIOSIS – DIABETES

Are you interested in tracking your emotional well-being while in care at The Source Chiropractic? _____ YES _____ NO

What are your expectations with care at The Source Chiropractic? _____

PRINT NAME

SIGNATURE

DATE